



In keeping with Kern County Cancer Foundation’s mission to assist eligible residents of Kern County with their cancer-treatment costs, the Board of Directors welcomes your application for financial assistance.

**YOU MUST LIVE IN KERN COUNTY TO APPLY FOR THIS PROGRAM.**

**To be considered for assistance, you must fill out the application completely and submit all additional documents. Be sure to answer every question- DO NOT SKIP ANY QUESTIONS—and provide all items listed on the Application Checklist**

If you are approved to receive assistance, the date we receive your COMPLETE application will serve as your eligibility date. Total payments by the Kern County Cancer Foundation for your cancer treatment have a lifetime limit.

**Use to help prepare your application and keep for your records.**

## **Application Checklist**

**Your application is complete when ALL required items listed below are received**

- \_\_\_\_ 1. A completed and signed Application for Financial Assistance**
  
- \_\_\_\_ 2. Copies of applicant's income tax returns for the last two years, copies of all bank statements for the past three months, and copies of the three most recent statements for all other accounts, such as retirement accounts, investment accounts, annuities, etc. If taxes were not filed for the last two years, provide copies of all bank statements and other statements for the last six months and a written explanation why taxes were not filed.**
  
- \_\_\_\_ 3. Income verification: For example: copies of paychecks or disability check stubs for the last two months, or copies of Social Security benefit statements, etc.**
  
- \_\_\_\_ 4. Copy of Itemized Insurance/Cobra Premium Bill (with information on individual medical premium cost.)**
  
- \_\_\_\_ 5. Copies of application(s) and/or response letter(s) from all programs to which applicant has applies, such as Medi-Cal, Breast and Cervical Cancer Treatment Program, etc.**
  
- \_\_\_\_ 6. Release #1: A signed release allowing Kern County Cancer Foundation to discuss applicant's health information with medical providers.**
  
- \_\_\_\_ 7. Release #2: A signed release allowing Kern County Cancer Foundation to discuss applicant's health information with family and/or friends.**
  
- \_\_\_\_ 8. For insured applicants (including Medicare and Medi-Cal), a copy of the insurance card(s), front and back.**

Kern County  
**Cancer Foundation**  
*Local support for local needs*

**6401 Truxtun Ave. Suite 280 Bakersfield, CA 93309**

**Phone: (661) 616-6430 Fax: (661) 616-1691**

**Application for Financial Assistance**

**1. Applicant's Name**

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**2. Street Address**

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**3. Mailing address if different from street address**

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**4. City**

**5. State**

**6. Zip Code**

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**7. Home Phone**

**8. Work/cell  
phone**

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**9. E-mail**

**10.  
Diagnosis/Date  
of diagnosis**

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**11. Date of birth**

**12. Social Security number**

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**13. Are you currently on active treatment (chemotherapy or radiation)? Yes No**

**14. What was the date of your last treatment? \_\_\_\_\_**

**15. How often do you come for visits? Daily/Weekly/Monthly/Other \_\_\_\_\_**

**16. If there are other people living in your household, fill out the section below:**

	Applicant's spouse, partner or significant other	Household Member	Household Member	Household Member
<b>First Name</b>				
<b>Last Name</b>				
<b>Date of birth</b>				
<b>Relationship to Applicant</b>				
<b>Gender</b>	M/F	M/F	M/F	M/F
<b>Marital Status</b>	Single	Single	Single	Single
	Married	Married	Married	Married
	Divorced	Divorced	Divorced	Divorced
	Separated	Separated	Separated	Separated
	Widowed	Widowed	Widowed	Widowed
<b>Employed?</b>				
<b>Name of employer</b>				
<b>Disabled</b>	Y/N	Y/N	Y/N	Y/N
<b>If disabled</b>	Temporary	Temporary	Temporary	Temporary
	Permanent	Permanent	Permanent	Permanent

**17. Provide information on income/assets:**

*Put "n/a" or '0' if applicable. All spaces must be completed. Do not leave blanks.*

<b>Income (Self)</b>	<b>Total \$ Amount (Monthly)</b>	<b>Income (Partner)</b>	<b>Total \$ Amount (Monthly)</b>
Salary		Salary	
Pension		Pension	
Social Security		Social Security	
Disability		Disability	
Unemployment		Unemployment	
Worker's Comp.		Worker's Comp.	
Alimony		Alimony	
Other (specify source)		Other (specify source)	
<b>TOTAL</b>		<b>TOTAL</b>	

<b>Assets (Household)</b>	<b>Total \$ Value</b>
Residence	
Real Estate Property	
Certificates of Deposit	
Savings	
Checking	
Retirement Account (IRA, 401K, etc.)	
Year, make, model & mileage of car(s)	1. 2.
Other (specify)	
<b>TOTAL</b>	

**18. Provide information on monthly household expenses:**

<b>Living Expenses</b>	<b>Total \$ Cost (Monthly)</b>	<b>Medical Expenses</b>	<b>Total \$ Cost (Monthly)</b>
<b>Food</b>		<b>Medical Insurance Premiums</b>	
<b>Mortgage</b>		<b>Doctor Fees</b>	
<b>Property Taxes</b>		<b>Lab Tests</b>	
<b>Rent</b>		<b>Prescriptions</b>	
<b>Transportation (gas, insurance, car payment, etc.)</b>		<b>Other Medical Expenses (specify)</b>	
<b>Utilities</b>			
<b>Other (specify expense)</b>		<b>Other (specify)</b>	
<b>TOTAL</b>		<b>TOTAL</b>	

19. What is/was your occupation? \_\_\_\_\_

20. Are you currently employed? Yes No

21. If yes, name of employer \_\_\_\_\_

22. If no, what was your last date of employment? \_\_\_\_\_

23. Are you eligible for COBRA medical insurance benefits? Yes No

24. If you currently have COBRA when did it begin? \_\_\_\_\_ When will it term? \_\_\_\_\_

25. Are you a U.S. military veteran? Yes No

26. If yes, are you eligible for VA medical benefits? Yes No

27. Have you applied for Medi-Cal? Yes No

28. If yes, application date \_\_\_\_\_ Application status \_\_\_\_\_

29. Have you applied for the Breast and Cervical Treatment Program (if applicable)? Yes No

30. If yes, application date: \_\_\_\_\_ Application status \_\_\_\_\_

31. Do you have life insurance? \_\_\_\_\_ Amount? \_\_\_\_\_ Is there a cash out value? \_\_\_\_\_

32. Do you have a cancer plan (AFLAC, principal, etc)? \_\_\_\_\_  
How much money has been received or plan to receive from it? \_\_\_\_\_

Do you have a GO FUND ME account? \_\_\_\_\_ Amount raised? \_\_\_\_\_

33. Are you eligible for Medicare? Yes No

34. If yes, what is the name of Medicare health plan (Senior Secure, SCAN, Secure Horizons, etc.), if applicable): \_\_\_\_\_

35. Monthly medical premium \_\_\_\_\_ (patient only)

- 36. Annual deductible \_\_\_\_\_
- 37. Annual Out of pocket Maximum \$ \_\_\_\_\_
- 38. Do you have a Medicare prescription plan? Yes No
- 39. If you are NOT eligible for Medicare, do you have private insurance? Yes No
- 40. If yes, what is the name of insurance carrier? \_\_\_\_\_
- 41. Monthly medical premium \$ \_\_\_\_\_ (patient only)
- 42. Annual deductible \$ \_\_\_\_\_
- 43. Annual Out of pocket Maximum \$ \_\_\_\_\_
- 44. Are you covered by Medi-Cal? Yes No
- 45. If yes, what is your monthly share of cost (SOC) \$ \_\_\_\_\_
- 46. Name of doctor managing your cancer care \_\_\_\_\_
- 47. Doctor's phone number \_\_\_\_\_
- 48. What type of assistance are you requesting for your cancer-treatment costs?

*Please have social worker or financial counselor help you with this section*

- 1. No Insurance: Requesting assistance with all cancer related costs. (Please list costs separately.)
- 2. Insurance: Requesting assistance with insurance premiums
- 3. Insurance: Requesting assistance with co-pays/co-insurance
- 4. Insurance: Requesting assistance with deductible
- 5. Insurance: Requesting assistance with out of pocket max
- 6. Medi-Cal: Requesting assistance with the share of cost, amount: \_\_\_\_\_
- 7. Other: Requesting assistance with: \_\_\_\_\_

***(must be directly related to cancer treatment)***

If you have applied for any other financial assistance programs, please list them here with the amount of your grant and dates eligible:

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If any programs are listed in previous section, please explain help received from the mentioned program(s):

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**I verify all information provided in this application and accompanying documents is accurate and valid.**

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Read, sign and submit.**

**CRITERIA FOR ELIGIBILITY**

**Applicant must:**

- **Be a resident of the Bakersfield or surrounding communities and receiving cancer treatment in the Bakersfield area. (Out-of-area cancer treatment may be considered when referred by a local oncologist because the treatment is unavailable locally.)**
- **Have a valid Social Security number**
- **Have a cancer diagnosis confirmed by a licensed physician.**
- **Provide documentation demonstrating financial need**
- **Request assistance limited to cancer treatment**

**CONDITIONS OF PARTICIPATION**

- **Financial assistance given will be paid directly to the provider of services.**
- **Providers must be in Kern County Cancer Foundation’s participating network.**
- **Benefits scope will be determined on an individual basis based on the client’s needs.**
- **Updated application is required every six months or upon request to assess eligibility.**
- **Eligibility decisions are subject to review by the Board of Directors**

**CERTIFICATION, WAIVER AND RELEASE**

*I certify that the information contained in this application is true and correct and that I am a patient in need of financial assistance for medical care and treatment.*

**By signing below, I hereby acknowledge that the Kern County Cancer Foundation, including the Board of Directors, honorary board members, members, officers, volunteers, employees, and/or agents (collectively, “Fund”), has sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that the Fund is not obligated to make or continue such discretionary financial assistance payments to me or on my behalf. I understand and hereby acknowledge that the Fund reserves the right to refuse or terminate any and all payments for any reason at any time and without notice. The Fund shall not be liable for any injury, disease, death or other harm, which may result following any termination or refusal to provide financial assistance. I also understand and acknowledge that any financial assistance provided by the Fund to pay for medical treatment, care or prescriptions is not assignable and that any assignment thereof shall be void.**

**By signing below, I hereby acknowledge that the Fund is not responsible for any diagnosis, selection or appointment of physician(s) or medical treatment I require. In reviewing this application, the Fund in no way shall be deemed to have issued a diagnosis of my medical condition or to have recommended treatment. Any evaluation of medical records is for the sole purpose of evaluating this application for financial assistance.**

**By signing below, I hereby release, waive, and discharge the Fund from any and all liability, and further covenant not to sue the Fund, as a result of any medical treatment or refusal of treatment in any way associated with this application for financial assistance or which I may receive in conjunction with any funds provided by the Fund. I hereby acknowledge that payments by the Fund for medical care and/or treatment, including any payments for prescriptions, will not subject the Fund to any liability for any injuries I may received in connection with such treatment, care or use of prescriptions. I expressly release the Fund from any and all liability under any cause of action in connection with any injury, disease or death resulting form the medical care, treatment and/or prescriptions I may receive. In the event of a dispute, the prevailing party shall be entitled to have and recover all costs and expenses, including all attorneys’ fees. I expressly agree that this Certification, Waiver and Release is intended to be as broad and inclusive as is permitted by the laws of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.**

*I certify that I have read and voluntarily signed this Application and Certification, Waiver and Release, and agree that no oral representations, statements or inducement apart from what is contained in this application have been made.*

**Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_**

**Release #1**

**Fill out, sign and submit.**

**This allows us to communicate with your medical providers.**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

To Whom It May Concern:

For the purpose of continued medical care, I hereby authorize **Kern County Cancer Foundation** and its representatives to discuss my Application for Financial Assistance (including but not limited to my financial information, diagnosis and treatment) and related medical care with physicians/medical providers (and their representatives) and social workers/financial counselors as needed.

I also authorize the release, as needed, of any medical records and information by my medical care providers to **Kern County Cancer Foundation**.

\_\_\_\_\_  
**Patient Signature / Date of birth**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**



Release # 2

Fill out, sign and submit.

This allows us to communicate with your friends and family.

List their names below.

### Authorization for Release of Protected Health Information

I hereby authorize \_\_\_\_\_  
List names of persons authorized to discuss/release your health information

to obtain my information from and/or release my information to: **Kern County Cancer Foundation**

**This authorization is for full disclosure of all health care information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that this revocation will not apply to information that has already been released based on this authorization.

If I do not specify any expiration date, event or condition, this authorization will expire in one year. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to ensure treatment.

**Patient Signature:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
(PRINT)

**Patient Social Security no.** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Cell/Phone** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Read and keep for your records**

**Kern County Cancer Foundation  
ADOPTED POLICY FOR COST CAPITATION**

1. Contingent upon availability of funds, Kern County Cancer Foundation's Patient Assistance Policy is as follows:

- Pre-patient lifetime cap of \$50,000 for cancer treatment for approved treatment plan. Emergency services and/or hospitalization not part of the approved treatment plan will not be covered.
  - A social worker/financial counselor at the facility where care is administered will assist the patient in applying for programs (i.e., BCCTP, Medi-Cal, etc.) that he/she may be eligible for at the beginning and during the course of treatment.
  - Applicant will be required to provide KCCF with a response letter from all of the above programs he/she has applied to prior to initial approval of KCCF for assistance and any subsequent approvals.
  - A treatment plan and close cost estimate will be required from the patient's physician/provider. A letter will be sent to the physician/provider stating that the patient has applied to KCCF and we are requiring a close cost estimate prior to approval.
  - Each applicant will sign a release allowing the KCCF to discuss his/her care with the physician/provider and social worker/financial counselor.

II. All patients will be enrolled (if they qualify) in Pharmaceutical Patient Assistance Programs at the facility where care is administered.

III. Patients will be required to reapply for financial assistance every six months.