Kern County Cancer Foundation

Local support for local needs

In keeping with Kern County Cancer Foundation 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, MISP, Breast and Cervical Cancer Treatment Program, etc.

_____6. A signed release allowing Kern County Cancer Foundation to discuss applicant's health information with medical providers. Release #1

_____7. A signed release allowing Kern County Cancer Foundation to discuss applicant's health information with family
and/or friends. Release #2

_____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

6501 Truxtun Ave. Suite Bakersfield, CA 93309
Phone: (661) 862-7136 Fax: (661) 862-7136

Application for Financial Assistance

1. Applicant's Name

2. Street Address

3. Mailing address if different from street address

4. City **5. State** **6. Zip Code**

7. Home Phone **8. Work/cell phone**

9. E-mail **10. Diagnosis/Date of diagnosis**

11. Date of birth **12. Social Security number**

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
First Name				
Last Name				
Date of birth				
Relationship to applicant				
Gender	M/F	M/F	M/F	M/F
Marital Status	Single	Single	Single	Single
	Married	Married	Married	Married
	Divorced	Divorced	Divorced	Divorced
	Separated	Separated	Separated	Separated
	Widowed	Widowed	Widowed	Widowed
Employed?				

Name of employer				
Disabled	**Y/N**	**Y/N**	**Y/N**	**Y/N**
If disabled	**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.

Income (self)	Total $ Amount (Monthly)	Income (partner)	Total $ Amount (Monthly)
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)**	
TOTAL		**TOTAL**	

Assets (household)	Total $ Value
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)	
TOTAL	

18. Provide information on monthly household expenses:

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

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_____

33. Other programs applied for, dates & application status_____

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34. Are you eligible for Medicare? Yes No

35. If Yes,

36. Name of Medicare health plan (Senior Secure, SCAN, Secure Horizons, etc.), if applicable)

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37. Monthly medical premium _____ (patient only)

38. Annual deductible _____

39. Annual Out of pocket Maximum $_____

40. Do you have a Medicare prescription plan? Yes No

41. If you are not eligible for Medicare, do you have private insurance? Yes No

If Yes,

42. Name of insurance carrier _____

43. Monthly medical premium $_____ (patient only)

44. Annual deductible $_____

45. Annual Out of pocket Maximum $_____

46. Are you covered by Medi-Cal? Yes No

47. If Yes, what is your monthly Share of Cost (SOC) $_____

48. Name of doctor managing your cancer care _____

49. Doctor's phone number _____

50. 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 on a separate page).
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:
_____
_____
_____
_____

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

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 herby acknowledge that the Kern County Cancer Foundation, including the Board of Directors, honorary board members, members, officers, volunteers, employees, and/or agents (collectively, "Foundation"), has sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that the Foundation 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 Foundation reserves the right to refuse or terminate any and all payments for any reason at any time and without notice. The Foundation 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 Foundation to pay for medical treatment, care or prescriptions is not assignable and that any assignment thereof shall be void.

By signing below, I herby acknowledge that the Foundation is not responsible for any diagnosis, selection or appointment of physician(s) or medical treatment I require. In reviewing this application, the Foundation 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 Foundation from any and all liability, and further covenant not to sue the Foundation, 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 Foundation. I hereby acknowledge that payments by the Foundation for medical care and/or treatment, including any payments for prescriptions, will not subject the Foundation to any liability for any injuries I may received in connection with such treatment, care or use of prescriptions. I expressly release the Foundation 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_____

Fill out, sign and submit.
Release #1
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**

Fill out, sign and submit.
Release # 2
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/other 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 Patient Assistance Policy is as follows:

   A. 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.

1. A social worker/financial counselor at the facility where care is administered will assist the patient in applying for programs (i.e., MISP,BCCTP, Medi-Cal, etc.) that he/she may be eligible for at the beginning and during the course of treatment.

2. 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.

3. 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.

4. 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.