

In keeping with Desert Cancer Foundation's mission to assist eligible residents of the Coachella Valley area with their cancer-treatment costs, the Board of Directors welcomes your application for financial assistance.

**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 Desert Cancer Foundation for your cancer treatment have a \$50,000 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, plus copies of all **bank statements** for the past three months. If taxes were **not** filed for those years, provide copies of all bank 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. Copies of application(s) and/or response letter(s)** from all programs to which applicant has applied, such as Medi-Cal, MISP, Breast & Cervical Cancer Treatment Program, etc.
  
- \_\_\_\_\_ **5. A signed release** allowing Desert Cancer Foundation to discuss applicant's health information with **medical providers. Release #1**
  
- \_\_\_\_\_ **6. A signed release** allowing Desert Cancer Foundation to discuss applicant's health information with **family and/or friends. Release #2**
  
- \_\_\_\_\_ **7.** For insured applicants (including Medicare and Medi-Cal), **a copy of the insurance card(s), front and back.**

**Fill out and submit.**

**DESERT CANCER FOUNDATION**  
 A California Nonprofit Public Benefit Corporation  
 74091 Larrea Street, Palm Desert, CA 92260  
 Phone: (760) 773-6554 Fax: (760) 773-6532

## Application for Financial Assistance

1. Applicant's name \_\_\_\_\_
2. Street address \_\_\_\_\_ (do not list P.O. Box unless homeless)
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 \_\_\_\_\_
11. Date of birth \_\_\_\_\_ Age \_\_\_\_\_ 12. Social Security number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

13. 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	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital status	<input type="checkbox"/> Single	<input type="checkbox"/> Single	<input type="checkbox"/> Single	<input type="checkbox"/> Single
	<input type="checkbox"/> Married	<input type="checkbox"/> Married	<input type="checkbox"/> Married	<input type="checkbox"/> Married
	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed
Employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of employer				
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If disabled	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary
	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent

**Fill out and submit.**

**14. PROVIDE INFORMATION ON HOUSEHOLD INCOME AND ASSETS:**

<b>INCOME</b>	<b>Total \$ Amount</b>	<b>ASSETS</b>	<b>Total \$ Value</b>
<b>Salary</b>	Monthly	<b>Residence</b>	
<b>Pension</b>	Monthly	<b>Real estate property</b>	
<b>Social Security</b>	Monthly	<b>Certificates of Deposit</b>	
<b>Disability</b>	Monthly	<b>Savings</b>	
<b>Unemployment</b>	Monthly	<b>Checking</b>	
<b>Worker's Compensation</b>	Monthly	<b>Retirement accounts (IRA, 401K, etc.)</b>	
<b>Alimony</b>	Monthly	<b>Year, make, model &amp; mileage of car(s)</b>	1. 2. 3.
<b>Other (specify source)</b>	Monthly	<b>Other (specify)</b>	
<b>TOTAL</b>	Monthly	<b>TOTAL</b>	

**15. PROVIDE INFORMATION ON MONTHLY HOUSEHOLD EXPENSES:**

<b>LIVING EXPENSES</b>	<b>Total \$ Cost</b>	<b>MEDICAL EXPENSES</b>	<b>Total \$ Cost</b>
<b>Food</b>	Monthly	<b>Medical insurance premiums</b>	Monthly
<b>Mortgage</b>	Monthly	<b>Doctor fees</b>	Monthly
<b>Property taxes</b>	Circle One: Annual OR Monthly	<b>Lab tests</b>	Monthly
<b>Rent</b>	Monthly	<b>Prescriptions</b>	Monthly
<b>Transportation (gas, insurance, loan payment, etc.)</b>	Monthly	<b>Other medical expenses (specify)</b>	Monthly
<b>Utilities</b>	Monthly		
<b>Business expenses</b>	Monthly		
<b>Other (Credit cards, etc.)</b>	Monthly	<b>Other (specify)</b>	
<b>TOTAL</b>		<b>TOTAL</b>	

**Fill out and submit.**

16. Are you currently employed? Yes No

17. If Yes, name of employer \_\_\_\_\_

18. If No, what was your last date of employment? \_\_\_\_\_

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

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

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

22. If Yes, application date \_\_\_\_\_ Application status \_\_\_\_\_

23. Have you applied for MISP? Yes No

24. If Yes, application date \_\_\_\_\_ Application status \_\_\_\_\_

25. Other programs applied for, dates & application status \_\_\_\_\_

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26. Are you eligible for Medicare? Yes No

27. If Yes,

28. Name of Medicare health plan (Senior Secure, SCAN, Secure Horizons, etc), if applicable):  
\_\_\_\_\_

29. Monthly premium \_\_\_\_\_

30. Annual deductible \_\_\_\_\_

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

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

33. If Yes,

34. Name of insurance carrier \_\_\_\_\_

35. Monthly premium \$ \_\_\_\_\_

36. Annual deductible \$ \_\_\_\_\_

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

38. If Yes, what is your monthly Share of Cost (SOC) \$ \_\_\_\_\_

39. Name of doctor managing your cancer care \_\_\_\_\_

40. Doctor's phone \_\_\_\_\_

**Fill out, sign and submit.**

**41. What type of assistance are you requesting for your cancer-treatment costs?**

**42. NO INSURANCE / Request assistance with all costs**

**43. INSURANCE / Request assistance with insurance premium**

**44. INSURANCE / Request assistance with co-pays / co-insurance**

**45. MEDI-CAL / Request assistance with Share of Cost**

**46. OTHER / Request assistance with:** \_\_\_\_\_  
(*must be directly related to cancer treatment*)

**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 Coachella Valley or surrounding communities and receiving cancer treatment in the Coachella Valley. (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 Desert 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 Desert 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 hereby 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 receive 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 from 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 **Desert 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 **Desert 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: **Desert 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 an 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.**

**DESERT CANCER FOUNDATION  
ADOPTED POLICY FOR COST CAPITATION**

**(adopted by Board of Directors on 3/15/05)**

I. Contingent upon availability of funds, Desert Cancer Foundation's Patient Assistance Policy is as follows:

A. Per-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., MISAP, 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 DCF with a response letter from all of the above programs he/she has applied to prior to initial approval of DCF financial 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 DCF and we are requiring a close cost estimate prior to approval.

4. Each applicant will sign a release allowing the DCF 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.