Dear Applicant,

Thank you for your interest in East Texas Cancer Alliance of Hope (ETxCAH) Financial Assistance Program. EtxCAH is a non-profit organization designed to assist with the financial burden many individuals are faced with have been given a cancer diagnosis.

Enclosed is the ETxCAH application for assistance. Please note that all applications must be submitted to ETxCAH by a referring professional (i.e. your family doctor, oncologist, social worker, or other health care professional who is involved in your care). Please read the instructions very carefully and fill out the application completely. Also, please be sure to list all your current expenses and complete the income information. ETxCAH will use the provided information to gain a complete understanding of your financial situation.

Please note, incomplete applications or applications submitted by clients will not be reviewed which will delay any funds being released. Also, this application is not a guarantee for financial assistance.

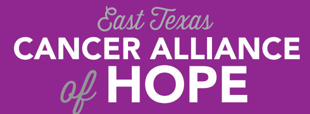
Referring professionals are asked to print and mail this application to the address below or visit our webpage at www.etxcancerallianceofhope.org and submit an application.

East Texas Cancer Alliance of Hope
P.O. Box 151114
Lufkin, TX 75915

Thank you again for your interest in East Texas Cancer Alliance of Hope. If you have questions or concerns please give us a call at 936-632-6400 or email aberry@etxcancerallianceofhope.org

In Hope,

Ashley Berry
East Texas Cancer Alliance of Hope
Founder and Executive Director



FINANCIAL ASSISTANCE PROGRAM

Eligibility Requirements:

APPLICANTS MUST MEET THE FOLLOWING QUALIFICATIONS TO BE CONSIDERED FOR FINANCIAL ASSISTANCE.

- Reside in East Texas as classified by DETCOG
  Angelina, Houston, Jasper, Nacogdoches, Newton, Sabine, San Augustine, San Jacinto, Polk, Shelby, Trinity, or Tyler Counties
- Have a cancer diagnosis as certified by a healthcare provider
- Be in active treatment or within a three-month period of cancer treatment.
  Active treatments include chemotherapy, radiation therapy, or cancer related surgeries.
- Patient declines active treatment and is admitted to a hospice service.
- Have a household income less than 250% of the 2018 national Poverty Limits.

HOUSEHOLD SIZE	100%	133%	150%	200%	250%	300%	400%
1	$12,060	$16,040	$18,090	$24,120	$30,150	$36,180	$48,240
2	$16,240	$21,599	$24,360	$32,480	$40,600	$48,720	$64,960
3	$20,420	$27,159	$30,630	$40,840	$51,050	$61,260	$81,680
4	$24,600	$32,718	$36,900	$49,200	$61,500	$73,800	$98,400
5	$28,780	$38,277	$43,170	$57,560	$71,950	$86,340	$115,120

- Must be able to provide all proof of income for each person in the household over the age of 18 years. Choose TWO of the following items for proof.
  - Bank statements from the last two months
  - Pay stub for the last two months
  - Social Security benefit letter
  - Social Security 1099
  - Notarized statement from employer
  - Copy of Social Security check
- If client has no income
  Client needs to provide a notarized letter stating the reason for no income
- Have resources** totaling less than
  - $9,000.00 (single individual)
  - $12,000.00 (Couple)
  - $15,000.00 (Family)
- Demonstrate attempts to apply for other forms of community assistance
  List other agencies from which you have applied or requested funding.

Financial assistance will be considered for applicants that meet the above qualifications.

**Resources include:
- Checking Account and or cash on hand
- Savings Account or Money Market Accounts
- Stocks or Bonds
- CDs
- Mutual Funds

**Resources do not include
- Primary residence
- Automobiles

***LOCAL** SUPPORT for **LOCAL** PEOPLE*

GUIDELINES

Payments will be made directly to the company owed. Therefore, applicants must supply copies of the bill, late notices, mortgage statement, statement from a landlord and his/her contact information, or any additional information necessary for payment.

Financial Assistance will be awarded to assist with following expenses (as applicable):

- Utility Bills- Gas, Water, Electric
- Gas Vouchers
- Nutritional Assistance
- Durable Medical Equipment
- Insurance Co-Pays
- Medication not covered by Insurance
- Restaurant Vouchers
- Partial Rent/Mortgage Payment
- Lodging Expenses

There is an annual cap of $500.00 per applicant.

Applicants must be referred by a physician, physician assistant, nurse, social worker, or patient account repersenitive.

Only completed applications will be considered.

APPLICATION

TO BE FILLED BY A HEALTHCARE PROFESSIONAL

PATIENT FULL NAME: ____ DATE OF BIRTH ____/____/____

ADDRESS: ____ PHONE _____-_____-______

WHAT ARE THE CIRCUMSTANCES CAUSING THIS FAMILY TO SEEK ASSISTANCE?

____

____

____

____

____

PLEASE PICK THE CATEGORY THAT BEST DESCRIBES HOW THIS REQUEST WILL BENEFIT THE CLIENT/PATIENT? PLEASE CHECK ALL THAT APPLY.

- ◯ UTILITY BILLS: GAS, ELECTRIC, WATER
- ◯ GAS VOUCHERS
- ◯ NUTRITIONAL ASSISTANCE
- ◯ DURABLE MEDICAL EQUIPMENT
- ◯ INSURANCE CO-PAYMENTS
- ◯ MEDICATION NOT COVERED BY INSURANCE
- ◯ RESTAURANT VOUCHERS
- ◯ PARTIAL RENT/MORTGAGE PAYMENT
- ◯ LODGING EXPENSES

PLEASE LIST WHO THE CHECK SHOULD BE MADE PAYABLE TO

****NOTE** NO PAYMENTS ARE MADE DIRECTLY TO CLIENTS**

PAYABLE TO: ___________________________________ ATTENTION TO: ___________________________

ADDRESS: ____ PHONE _____-_____-______

ACCOUNT NUMBER: ____ AMOUNT REQUESTED $__________

I HAVE REVIEWED THIS APPLICATION AND I AGREE WITH THE FUNDING NEED.

REFERRING HEALTHCARE PROFESSIONAL NAME _________________________________ DATE ____/____/____

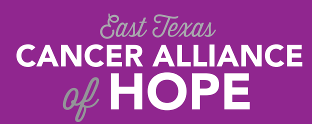
ORGANIZATION ____ PHONE _____-_____-______

PLEASE EMAIL THIS FORM TO ABERRY@ETXCANCERALLIANCEOFHOPE.ORG
or **MAIL** TO P.O. BOX 151114 LUFKIN, TX 75915

FOUNDATION USE ONLY:

PRINT NAME ___________________________ SIGNATURE ______________________________

CHECK NUMBER ___________ CHECK AMOUNT $_____________ CHECK DATE ____/____/____



FINANCIAL ASSISTANCE APPLICATION

ALL REQUEST MUST BE PRESENTED IN WRITING USING THIS FORM ONLY.
PLEASE INCLUDE ANY SUPPORTING DOCUMENTS YOU MAY HAVE.

PATIENT FULL NAME: ____ DATE OF BIRTH ____/____/____

MALE FEMALE LAST FOUR OF APPLICANT'S SOCIAL SECURITY __________

SINGLE MARRIED DIVORCED WIDOWED SEPARATED

NAME(S) OF PERSON(S) DEPENDENT ON INCOME: ____

ETHNICITY ASIAN AFRICAN AMERICAN HISPANIC NATIVE AMERICAN WHITE OTHER

ADDRESS: ____

COUNTY __________________________ PHONE _____-_____-______ EMAIL ______________________________________

WHAT TYPE OF CANCER DO YOU HAVE? ___________________________________ DATE OF DIAGNOSIS ____/____/____

ARE YOU CURRENTLY RECEIVING TREATMENTS? __________ WHO IS YOUR ONCOLOGIST? _______________________

IF YOU ARE NOT RECEIVING TREATMENT, WHEN WAS YOUR LAST TREATMENT? ____/____/____

HAVE YOU RECEIVED ASSISTANCE FROM EAST TEXAS CANCER ALLIANCE OF HOPE IN THE PAST? _________________

AMOUNT REQUESTING $ ________

WHAT DO YOU NEED ASSISTANCE WITH? ____

____

____

WHY DO YOU FEEL YOU NEED THIS HELP? ____

____

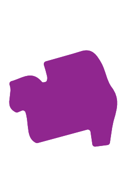
____

LIST OTHER AGENCIES YOU HAVE CONTACTED FOR HELP AND WHEN: ____________________________________

____

____

East Texas
CANCER ALLIANCE
of HOPE



HOUSEHOLD SIZE	250%
1	$30,150
2	$40,600
3	$51,050
4	$61,500
5	$71,950

**U.S. Dept. of Health and Human Services