Cancer Patient Care Fund
Application for Assistance

Good Samaritan HEALTH SERVICES Foundation
Supporting Heart of America Medical Center & Haaland Estates

The Cancer Patient Care Fund is designed to lessen financial burdens for cancer patients who reside in the Rugby area.

WHO IS ELIGIBLE:

- Applicants who live in the Rugby area, which is defined as Rugby, Balta, Orrin, Towner, Willow City, Upham, Leeds, Maddock, Knox, Rolette, Wolford, Overly, or Dunseith zip codes. Proof of residency is required.
- Applicants must have selected their provider, practitioner, or supplier and have a treatment regimen in place before applying for benefits, but remain free to change provider(s) while receiving assistance.
- Eligibility guidelines will be based on an "income only" sliding scale from two hundred to three hundred percent (200-300%) of the published poverty guidelines from the Federal Register.
    - Verification of income requires an applicant to provide:
        - A copy of their most recent Federal Income Tax Return or complete a Form 4506-T to verify they did not file Federal Income Tax.
        - Proof of any income from the most recent three months will also be requested and used to calculate an annualized gross salary which will be used as a basis for determining their level of qualification for the caring program.
        - Adequate information must be made available to determine eligibility for the program.
        - Self-employed individuals will be required to submit details of the most recent three months of income and expenses for the business.
    - If an application for Community Care has been accepted within the last 3 months, the applicant is automatically eligible to apply for this program without having to provide further income documentation. Proof of Income can be used from the recent Community Care application.

WHAT'S COVERED: Any healthcare-related expenses that will provide financial relief that is not covered by insurance or other Community Care programs. These expenses include costs of health insurance (copayments, premiums, deductibles), drug and device therapies, out-of-pocket expenses related to outpatient prescription drugs used to treat cancer-related ailments; and travel (gas, lodging, and meals) that were incurred during cancer treatment(s).

WHAT TO SUBMIT:

1. **Have you applied and been approved for the GSHS Community Care Program in the last 90 days?**
    - ☐ YES - no income verification needed – (See Community Care Program application).
    - ☐ NO - fill out the entire form.

2. **Complete the application form and attach copies of at least one of the following:**
    - ☐ Tax return and supporting schedules (previous year) ☐ Pay Stubs (most recent 3 months)
    - ☐ Bank Statements (most recent 3 months for all accounts) ☐ Social Security/Disability benefits
3. Proof from a medical provider that a treatment regimen has been put in place.
4. Proof of residence.
5. Copies of Healthcare related bills to be paid (medical bills not covered by insurance, appointment information showing where and when appointments are, travel expenses).

I, _____ hereby request that Heart of America Medical Center (HAMC) makes a determination of my eligibility for Cancer Patient Care Fund services through the Good Samaritan Health Services (GSHS) Foundation. I understand that the information which I submit will be subject to verification by GSHS Foundation, and if the information which I submit is determined to be false, the result will be a denial of Cancer Patient Care Fund services.

Services not eligible for the community care program include but are not limited to non-medically necessary services, household expenses, and cosmetic services.

1. Name: _____

First Middle Last

Physical Address: _____

Number and Street City State Zip Code

Mailing Address: _____

Number and Street City State Zip Code

Social Security # _____ Date of Birth: _____

Marital Status: Single Married Widow Divorced

Telephone: _____ Cell Phone: _____

If student: School_____ Full time _____ Part time _____

Occupation: _____ Date of unemployment, if applicable: _____

Employer: _____ Phone: _____

Employer Mailing Address: _____

Number and Street City State Zip Code

2. Spouse Name: _____

First Middle Last

Social Security # _____ Date of Birth: _____

Telephone: _____ Cell Phone: _____

If student: School_____ Full time _____ Part time _____

Occupation: _____ Date of unemployment, if applicable: _____

Employer: _____ Phone: _____

Employer Mailing Address: _____

Number and Street City State Zip Code

3. **Dependents:** (Household dependents that are claimed on your tax return. **Dependents over 18 must show proof of disability and/or verification of income if providing support to the household.)**

Name	Relationship	Date of Birth
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. **Income:**
   A. List the total gross income for the household below for the last 12 months.
   B. You must provide a copy of your most recent Federal Income Tax Return (or complete a Form 4506-T to verify that you did not file Federal income Tax); or
   C. You must provide us with verification of income for the last 3 months.

	Self	Spouse
Wage Income		
Farm or Self-Employment		
Social Services (Food Stamps, AFDC, WIF, etc.) Stamps, AFDC, WIF, etc.)		
Social Security/Disability		
Unemployment compensation		
Worker's Compensation		
Strike Benefits		
Alimony/Child Support		
Military Family Allotments		
Pension		

Income from Dividends/Interest		
Rental Property		
Inheritance		
Stocks/Bonds		
Other		
Subtotal:		
Household total		

5. Health Insurance:
Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance?
Yes No *If yes, please specify below*:

Insurance Name: _____ Policy # _____ Group # _____

Insurance Name: _____ Policy # _____ Group # _____

ASSISTANCE REQUEST
Please describe your needs: medications, specialized treatments, gas, lodging, insurance premium, etc.

_____

_____

_____

To make a determination on your application, please provide me with the following:

_____

Return requested documentation by: _____

I affirm that the information listed in this Request is true and correct to the best of my knowledge. I hereby authorize HAMC to investigate any information provided and I authorize the release of any information that HAMC deems necessary in making an eligibility determination.

_____ _____

Signature (person making this request) Date

Referring HAMC medical professional (optional): _____

AFTER SUBMISSION:

1. A submitted application is not a guarantee of receiving funds. Patients may apply as often as needed.
2. Awards are limited to a total of $1,000.00 per year, per patient, beginning with the date of the first award.
3. Assistance is granted in the form of gas cards, hotel vouchers, or direct payments to medical providers, pharmacies, and medical supplies companies.
4. The availability of funds depends on charitable donations to the Cancer Care Patient Fund.
5. You will be contacted by the Good Samaritan Health Services Foundation office with your application award decision. For more information, call the Foundation Director at 701-776-5455 ext. 2149.

For Office Use Only

This Document Was Received By:

Name: _____ Date: _____

What/Who was paid: _____ *Date:* _____ *Amount:* _____

What/Who was paid: _____ *Date:* _____ *Amount:* _____

What/Who was paid: _____ *Date:* _____ *Amount:* _____

What/Who was paid: _____ *Date:* _____ *Amount:* _____