Dundy County Cancer Fund
Guidelines for Awarding Financial Assistance

The intent of the Fund is to provide financial assistance to residents within the Dundy County Hospital Service area to aide with travel and medical expenses as they undergo cancer diagnostic testing and/or treatment.

Following are the guidelines, based on the bylaw of the committee, for determining if an applicant qualifies for assistance.

1. The patient must be diagnosed with cancer and receiving treatment or seeking diagnostic services for cancer. Doctor visits or treatments for other conditions are excluded.

2. The patient must live in the service area of Dundy County Hospital.

3. The patient must be an established patient within the Dundy County Hospital/Quality Health Care Clinic/Stratton Medical Clinic/Wauneta Clinic.

4. The patient must have an account that is in good standing within Dundy County Hospital/ Quality Health Care Clinic.

5. A note from the doctor's office or clinic must be attached to the application stating the cancer diagnosis and treatment plan (form attached to application).

6. Assistance can be granted for forthcoming appointments and/or retroactive appointments when applications verification, and/or receipts are submitted within a month of the appointment.

7. Each applicant is able to be granted, in designated amounts, up to $250.00 per calendar year.

8. Due to varying amounts within the fund, the committee will not grant more than 60% of the funds in the account.

9. Applications will be reviewed within 30 days ;)f being submitted.

10. All grants and funds provided by the Dundy County Hospital Cancer Fund Committee will be at the discretion of the committee.

11. Once requests are reviewed, the committee will respond to each applicant with a letter explaining the benefits rewarded or the reason for denial. Applicants that are denied by the committee will be referred to the financial advisor at Dundy County Hospital.

12. All guidelines and regulations established by the Dundy County Hospital Cancer Fund Committee are subject to change annually based on available funds and use of the grants.

13. Applications must include all signed forms and mailed to: Dundy County Hospital Cancer Fund ; PO Box 626 Benkelman, NE 69021. Please contact Alicia Aldridge at Dundy County Hospital 308-423-2204 with any questions or concerns.

Dundy County Cancer Fund

Application for Financial Assistance

Patient Name: _____ Date: _____

Patient Address: _____ Telephone: _____

Applicant Name (if different than patient): _____ Telephone: _____

Relationship of Applicant to Patient: ___Spouse ___Domestic Partner ___ Parent ___Other Family
___Support person (friend, neighbor, other)

Insurance (please list all active policies): _____
_____

Facility in which seeking treatment: _____

Address of Facility: _____

Doctor's Name: _____ Telephone: _____

Diagnosis: _____ Date of Diagnosis: _____

Describe individual/family needs for financial assistance: _____
_____
_____
_____
_____

Amount Requested (up to $250.00): _____

How will funds be used (e.g., diagnostic testing, on-going treatment, travel, food, etc.): _____
_____
_____
_____

Additional Comments: _____
_____
_____
_____
_____

For Committee Use Only:
Date Application Received by the Committee
Date Application Reviewed by the Committee
Application Granted for $_____

Denial Reason: _____
_____
_____

Dundy County Cancer Fund

Verification of Services

To: Doctor's Office

From: Dundy County Cancer Fund

RE: Verification of Diagnosis and Treatment

Please verify the diagnosis and treatment for _____ (Patient's Name) so that Dundy County Cancer Fund can assist him/her with travel and medical expenses throughout the cancer diagnostic and/or treatment process.

Diagnosis: _____

Treatment to be Provided: _____
_____

Thank you for your cooperation and assistance in helping this patient.

_____ _____
Signature of Doctor or Office Manager Date

Consent For Authorization of Medical Information

I authorize Dundy County Cancer Fund to receive information from my health care providers in order to assist and validate my diagnosis and treatments, so that I may be able to receive grants to assist in expenses.

I understand that I have the right to revoke this authorization at any time.

Authorization Expires: _____
One year from today's date

Patient Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

This letter of verification must be attached to the application for financial assistance.

Mail Completed Forms to:
Dundy County Hospital
Attn: Cancer Fund
PO Box 626
Benkelman, NE 69021