Community Cancer Care Fund

Financial assistance for those facing cancer

Before completing this application, please review the eligibility criteria on page 6.

Date _____ Amount Requested _____

(Maximum grant amount is $2,000)

Patient Information

First Name _____ Last Name _____

Birth date _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____

Email Address _____

Medical facilities where you are receiving care

Please list all hospitals, clinics, radiation centers, etc.

Name _____ City _____ Phone _____

Name _____ City _____ Phone _____

Name _____ City _____ Phone _____

Name _____ City _____ Phone _____

Allina Health

BUFFALO HOSPITAL FOUNDATION

You must fully complete all questions on this form for consideration. Please be as detailed as you can to explain your financial hardship. Incomplete questions will cause a delay in the application process.

Please explain how you are experiencing a financial hardship due to your cancer diagnosis

What additional expenses have you had to pay because of your cancer diagnosis?

Please list your most urgent financial needs (bills that you would like to be paid, grocery or gas cards) and amounts:

Patient Need	Amount	Bill Included
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Patient Financial Information

Household size: #adults: #children under 18:

Monthly Net Income (combined): Savings/Liquid Assets:

Monthly Expenses:

Rent/Mortgage: _____

Utilities (gas, electric, water, garbage): _____

Phone/Cable/Internet: _____

Transportation: _____

Insurance/Medical Bills: _____

Child Care: _____

Car Payment/Insurance: _____

Credit Cards: _____

Groceries: _____

Other (please list): _____

_____

_____

_____

Average Total Monthly Expenses: _____

Do you have health insurance: ☐ Yes ☐ No

Health insurance provider:

Deductible: Out of pocket maximum:

Who is your primary support person?

If you do not have a primary support person, can we help connect you to someone? ☐ Yes ☐ No

How did you learn about the Community Cancer Care Fund?

This section to be competed by your Oncologist or Oncology Nurse

Diagnosis Stage Date of Diagnosis

Current Treatment (check all that apply)

☐ Chemotherapy	Date of most recent treatment	_____
☐ Radiation	Date of last treatment	_____
☐ Surgery	Date of surgery	_____
☐ Hospice	Date entered	_____
☐ Palliative Care	Date entered	_____
☐ Bone Marrow Transplant	Date of transplant	_____
☐ Lymphedema	Date of most recent treatment	_____

What is the anticipated course of treatment (including dates)

☐ I attest that the patient has cancer and currently is being treated as stated above

Provider's Name Provider's Signature

Clinic Name Phone Number

For office use only

Assess means test results and make eligibility determination. Include rationale for why applicant does or does not meet criteria for funds:

Means testing completed by:

Name:

Title

Date:

All applications are strictly confidential and only the Buffalo Hospital Foundation Development Officer will have access to the name of the applicant.

Checklist for Community Cancer Care Fund Application

Before submitting your application, please be sure that you have included all of the following information. Failure to include the information will result in delays.

☐ Completed and signed application

☐ Information completed by oncologist or oncology nurse

☐ Copies of bill(s) or online statement(s) for payment. Do not send originals!

- If the request is for a rent payment, a copy of the lease, including the landlord's name and phone number, must be included.
- If the bill is paid electronically, a copy of the online statement must be included, along with the company name and billing address.
- The bill to be paid must be in the name of the patient. Joint accounts are acceptable, as long as the patient is named on the bill.
- The Community Cancer Care Fund cannot be used to make credit card payments and will not contact creditor on behalf of a patient to discuss terms or guarantee payment.

I have read and understand the Community Cancer Care Fund guidelines. I declare that the information on this form is true and correct to the best of my knowledge. I understand that all applications will be reviewed individually and that final determination will be made by the Community Cancer Care Fund team. All information reviewed is confidential.

Patient Signature _____ Date _____

Print Name _____

If you have any additional comments about your situation to share with us, please provide them on a separate sheet of paper. This may help us when reviewing your application. Thank you.

Applications can be mailed to:

Buffalo Hospital Foundation
303 Catlin Street
Buffalo, MN 55313

Applications can be faxed to:

763-684-7105
Attn: Community Cancer Care Fund

Eligibility Criteria

The Community Cancer Care Fund is only for people who are actively receiving care for cancer. No exceptions can be made to this guideline. Active treatment includes chemotherapy, radiation, bone marrow transplant, surgery, lymphedema, hospice, palliative care, etc.

The fund serves patients of all ages receiving care on the Buffalo Hospital Campus or living in our service area. Previous recipients may apply one year after their previous application, for a maximum of three grants allowed.

Incomplete applications will not be considered.

What does the emergency fund cover?

Basic living expenses such as mortgage or rent, car payments, heat, electricity or other utilities amd insurance. Food and gas cards can be issued upon request.

The Community Cancer Care Fund cannot be used to make credit card payments, pay for any medical expenses besides insurance premiums, or prepay expenses.

How do I apply?

Applications are available online at buffalohospital.org or by calling 763-684-6800. A completed application, along with a copy of the bill (no originals, please) that includes all pertinent information — amount owed, billing address, etc. — must be submitted to:

Buffalo Hospital Foundation, 303 Catlin Street, Buffalo, MN 55313

Or you can fax your application and information to 763-684-7105, Attention: Community Cancer Care Fund.

All pages of the application must be completed and signed. Incomplete applications will be returned and will not be reviewed until a completed application is submitted.

If the request is for a rent payment, a copy of the lease, including the landlord's name and phone number, must be included.

The Community Cancer Care Fund can be used to pay more than one bill. Please submit copies of all bills to be paid.

If the bill is paid electronically, a copy of the online statement must be included, along with the company name and billing address.

The bill to be paid must be in the name of the patient. Joint accounts are acceptable, as long as the patient is named on the bill.

The Community Cancer Care Fund will not contact a creditor on behalf of a patient to discuss terms or guarantee payment. All contact with the creditor must be handled by the patient.

How long does the process take?

All funding decisions are made by a five member committee consisting of: the Foundation Development Officer, a Foundation Board Member, three members of the community, at least one being a cancer survivor.

All applications are strictly confidential and only the Buffalo Hospital Foundation Development Officer will have access to the name of the applicant.

You will be contacted with a decision within one week of receipt of your application.

It will take approximately two weeks for financial assistance to be processed. Please be sure to plan accordingly.

A check will be issued and mailed directly to the creditor. A check cannot be made out to an individual.

The Community Cancer Care Fund reserves the right to make exceptions to providing funds for other extenuating circumstances.

Applicants who are denied funding may request an appeal.

The Community Cancer Care Fund is a program of the Buffalo Hospital Foundation and is funded by proceeds from the Street Party of Hope, gifts from donors, and occasional grants.