Eligibility Criteria

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

You must be at least 18 years old and be receiving care at the Cambridge Medical Center campus or live in one of the following counties: Isanti, Chisago, Plne, Mille Lacs or Kanabec and do not qualify for other similar programs.

Incomplete applications will not be considered.

Checklist for Hope 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.

☐ 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 Hope Fund can not be used to make credit card payments and will not contact a creditor on behalf of a patient to discuss terms or guarantee payment.

I have read and understand the Hope Fund guidelines. I declare that the information on this form is true and correct to the best ozf my knowledge. I understand that all applications will be reviewed individually and that final determination will be made by the Hope 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 or faxed to:

Cambridge Medical Center Foundation
Harbor Room
701 South Dellwood
Cambridge, MN 55008

Fax: 763-688-7941 (Attn: Hope Fund)

The Hope Fund is a program of the Cambridge Medical Center Foundation and is funded through the generous support of the Minnesota Affiliate of Susan G. Komen for the Cure.®

CAMBRIDGE MEDICAL CENTER FOUNDATION

Hope Fund Application

***Please read the eligibility criteria and entire application before completing this form.**

Date: _____ Amount Requested: _____

Patient Information:

First Name: _____ Last Name: _____

Birthdate: _____ Gender: ☐ Female ☐ Male

Address: _____ City: _____

State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email address: _____

Name of Oncologist: _____ Phone: _____

Name of Oncology Nurse: _____

Clinic Name and Location: _____

Medical facilities where you are receiving care: (list all hospitals, clinics, radiation centers, etc.)

Name: _____ City: _____ Phone: _____

Name: _____ City: _____ Phone: _____

Name: _____ City: _____ Phone: _____

Name: _____ City: _____ Phone: _____

If you are applying for food or gas assistance, please tell us the date of your last treatment:

_____

What type of treatment was this?

_____

This Section to be Completed by Your Oncologist or Oncology Nurse

Applicant's Name: _____

Diagnosis: _____ Stage: _____ Date of Diagnosis: _____

Current Treatment (Check all that apply:)

☐ Chemotherapy Date of most recent treatment: _____

☐ Radiation Date of last treatment: _____

Location of Radiation Center: _____

☐ Surgery: Date of surgery: _____

☐ Hospice: Date entered: _____

☐ Palliative Care Date entered: _____

☐ Bone Marrow Transplant Date of transplant: _____

☐ Lymphedema Date of most recent treatment: _____

☐ Cording Date of most recent treatment: _____

What is the anticipated course of treatment (including dates): _____

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

_____

Provider's Name Provider's Signature

Please tell us why financial assistance is being requested:

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:

Signature:

Title

Date:

All applications are strictly confidential and only the Cambridge Medical Center Foundation Development Officer will have access to the name of the applicant.

The following information is optional and will not affect your grant application. However, the information will help us apply for grant funding in the future.

Please list the people, including yourself, that live in your household:

Name	Date of Birth	Relationship
		Self

Do you have health insurance? ☐ Yes ☐ No

What type of insurance do you have?

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 Hope Fund?