Community Cancer Care Fund

Emergency financial assistance for those facing cancer

Who is eligible?

The Community Cancer Care Fund has been established for people who are actively receiving care for cancer. Active treatment includes chemotherapy, radiation, bone marrow transplant, surgery, lymphedemia, hospice or palliative care, etc.

The fund serves patients of all ages receiving care on the Buffalo Hospital Campus or living in our service area.

What does the emergency fund cover?

Basic living expenses such as mortgage or rent, car payments, heat, electricity or other utilities, insurance, and out of pocket medical expenses. Food and gas can be covered by the fund.

The Community Cancer Care Fund cannot be used to make credit card payments or prepay expenses.

How do I apply?

Applications are available online (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.

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 : Foundation Senior Development Associate, 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 Senior Development Associate will have access to the name of the applicant.

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

Please allow approximately two weeks for the financial assistance to be processed. Please 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 Pink Street Party, gifts from donors, and occasional grants.

Allina Health
BUFFALO HOSPITAL FOUNDATION

303 Catlin Street
Buffalo, MN 55313
763-684-6800

buffalohospital.org

Community Cancer Care Fund Application

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

Date _____ Amount Requested _____

Patient Information

First Name _____ Last Name _____

Birth date _____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Cell Phone _____

Email Address _____

Name of Oncologist _____ Phone _____

Name of Oncology Nurse _____

Clinic Name & Location _____

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 _____

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

_____

What type of treatment was this?

_____

This section to be competed 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

Radiology Center Location

☐ 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 cancer and currently is being treated as stated above

Provider's Name Provider's Signature

Please tell us why emergency financial assistance is being requested

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

Please state your most urgent financial need and the amount:

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 Community Cancer Care Fund?

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 Buffalo Hospital 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 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, cording, hospice, or palliative care, etc.

The fund serves patients of all ages receiving care on the Buffalo Hospital Campus or living in our service area.

Incomplete applications will not be considered.

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.

☐ 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:

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Applications can be faxed to:

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Attn: Community Cancer Care Fund

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