FINANCIAL ASSISTANCE FOR CANCER PATIENTS

A Service of Monroe County Cancer Supporters, a Missouri Non-profit Corporation

OBJECTIVE

Funds raised by *Monroe County Cancer Supporters* are disbursed to Monroe County residents diagnosed with cancer. The disbursements shall be given to cancer patients and their families to assist with expenses incurred for necessary medical treatment and care.

POLICY FOR FINANCIAL ASSISTANCE

Monroe County Cancer Supporters is committed to assisting as many Monroe County residents as possible who are diagnosed and being treated for cancer. Therefore, based on available funds, ***Monroe County Cancer Supporters*** establishes a disbursement limit for any individual applicant per six-month period. To be eligible to receive financial assistance from ***Monroe County Cancer Supporters***, the following conditions must be met:

1. The applicant must be a resident of Monroe County for at least six months.
2. The applicant must provide written documentation of a cancer diagnosis by their health care provider.
3. Upon approval by **Monroe County Cancer Supporters**, each applicant may receive financial assistance once within a six-month period, measured from the date of the disbursement. A recipient may apply for additional funds six months after the original date of approval by **Monroe County Cancer Supporters** as long as the patient is undergoing active, aggressive treatment. Patients following a maintenance treatment regimen are not eligible for recurring financial assistance.

PROCEDURE FOR ASSISTANCE

1. Complete and submit an Assistance Application to ***Monroe County Cancer Supporters***.
2. Applications must be accompanied by a written letter from a health care provider on the facility's letterhead, stating that cancer has been diagnosed.
3. ***Monroe County Cancer Supporters*** will review Assistance Applications. If additional information is required, the applicant will be notified.
4. Applicants meeting eligibility criteria will be notified as soon as possible if they will receive financial assistance. Please allow time for processing and disbursement by ***Monroe County Cancer Supporters*** volunteers.
5. Recipients may use funds from ***Monroe County Cancer Supporters*** as the recipient deems appropriate.

REAPPLYING FOR FINANCIAL ASSISTANCE

If treatment continues beyond six months from the original date of approval of financial assistance, or if cancer treatment becomes necessary at a later date, recipients may reapply for financial assistance six months from the initial date of approval by ***Monroe County Cancer Supporters*** as long as the patient is undergoing active, aggressive treatment. Patients following a maintenance treatment regiment are not eligible for recurring financial assistance. As with the initial application, an application for continued benefits must include a letter from a health care provider stating that the patient's active, aggressive cancer treatment or care is continuing or that a new cancer diagnosis has been made.

Monroe County Cancer Supporters

APPLICATION FOR FINANCIAL ASSISTANCE

22744 Monroe Road 277, Paris, MO 65275
(573)-473-2589, Fax to Attn: Annette Bell at 660-327-5909

ELIGIBILITY REQUIREMENTS FOR FINANCIAL ASSISTANCE

1. The applicant must be a resident of Monroe County for at least six months.
2. The applicant must provide written documentation of a cancer diagnosis by the health care provider.
3. Upon approval by **Monroe County Cancer Supporters**, each applicant may receive financial assistance once within a six-month period, measured from the date of the disbursement. A recipient may apply for additional funds six months after the original date of approval by **Monroe County Cancer Supporters** as long as the patient is undergoing active aggressive treatment. Patients following a maintenance treatment regimen are not eligible for recurring financial assistance.

Applicant's Name: _____Application Date: _____

☐ Check if the applicant is a minor. V.A. patients only, please enter last 4 digits of SSN:__ __ __ __

Mailing Address: _____
Street/P.O. Box City State Zip

Home Phone: _____Length of Time You Have Resided in Monroe County: _____

Contact Person (other than Applicant): _____Phone: _____

Mailing Address: _____
Street/P.O. Box City State Zip

Physician: _____Phone: _____

Address of Physician: _____
Street/P.O. Box City State Zip

Assignment of assistance payment to a person other than the applicant may be appropriate if the cancer patient is a minor or incapacitated. If this is the case, to whom should the payment be made? (Leave blank if the payment is to be made directly to the applicant.)

Recipient (other than Applicant):_____Phone:_____

Mailing Address:_____
Street/P.O. Box City State Zip

I have attached a written statement from my health care provider on the facility's letterhead stating that cancer has been diagnosed. I hereby give consent that this medical record may be made a part of my application for assistance to ***Monroe County Cancer Supporters***.
I understand that my application cannot be processed until I have submitted all required documents to the address shown on the top of this application.
By signing below, I certify that this request has been made voluntarily, that I have read and understand this application, that I am undergoing active, aggressive treatment, and that the **information** given above is accurate to the best of my knowledge.

Signature of applicant, parent, or legal guardian: _____

Date: _____

MCCS Representative: _____Date: _____