PATRICIA HALEY CHARITY

Cancer Patient Assistance Application

Request help with rent, utilities, doctor-visit copays, prescription copays, transportation and food.

Patient full name

Application date MM/DD/YYYY

I am requesting assistance with - check all that apply.

- ☐ Rent
- ☐ Utilities
- ☐ Doctor visit copays
- ☐ Prescription copays
- ☐ Transportation
- ☐ Food

How to apply

1. Complete patient, household and cancer-care information on **pages 2-4**.
2. Complete only the assistance pages you need on **pages 5-10**.
3. Use **page 11** for hardship details, no income or missing documents.
4. Review the checklist and sign **page 12**. Page 13 is for charity staff.

Proof to include

Proof of identity, household income and cancer care, plus the lease, utility bill, copay statement or appointment confirmation for the help requested. Each assistance page explains the documents needed. Attach copies and keep your originals.

Rent: signed lease and current rent statement or balance ledger.
Utilities: current bill and any disconnection notice.
Doctor visits: appointment proof and bill or copay estimate.
Prescriptions: pharmacy printout showing the patient cost.
Transportation: appointment date, time, pickup and destination.
Food: household details and any special food needs.

Questions or submission arrangements: 844-944-3198.
Type and save this PDF, or print on legal paper (8.5 x 14 inches). Use N/A when an item does not apply. Use an extra sheet if more space is needed.

Assistance is subject to review and available resources. An application does not guarantee payment or a ride. Staff must confirm any assistance arrangements.

Patient and contact information

Complete this page for every application.

Patient full name

Date of birth MM/DD/YYYY

Preferred name

Application date MM/DD/YYYY

Home address including apartment or unit

City

State

ZIP code

County

Mailing address if different or no fixed address

Best phone

Alternate phone

Email if used

Safe ways to contact you - check all that apply.

- ☐ Call
- ☐ Text
- ☐ Email
- ☐ Mail
- ☐ Voicemail

Best contact time or contact restrictions

Caregiver or person helping with this application

Name and relationship to patient

Phone

- ☐ Parent / legal guardian
- ☐ Caregiver
- ☐ Other helper

If patient is a minor, parent or guardian name

May we discuss this application with the helper named above? Select one.

- ○ Yes
- ○ No
- ○ No helper

Preferred language

Communication or access support needed

Referral agency or care-team contact if any

Referral phone

Household and finances

List people who live with you and share household income or expenses.

Patient full name

Date of birth MM/DD/YYYY

Include the patient. Use ages rather than full birth dates for other household members. Enter monthly income before deductions; write 0 if none.

Household member name	Relationship	Age	Monthly income $

Total people in household

Children under 18

Adults age 60 or older

Optional household information - check any that apply.

- ☐ Veteran in household
- ☐ Person with a disability
- ☐ Prefer not to answer

Income and benefits

Income sources - attach proof for each source. Do not count the same income twice.

- ☐ Wages / self-employment
- ☐ Social Security / SSI / SSDI
- ☐ Pension / unemployment
- ☐ Child support / regular support
- ☐ Other income
- ☐ No household income

Total household monthly income before deductions $

Current monthly take-home cash income $

SNAP or other food benefits per month $

Other income source or change in income

Typical monthly household expenses

Rent / housing $

Utilities $

Food $

Medical / insurance $

Transportation $

Other essential expenses $

Proof: recent pay stubs covering about 30 days, current benefit letters, or recent self-employment income and expense records. For irregular income, explain the time period used on page 11. If no income, complete the declaration on page 11.

Cancer care and insurance

Complete the patient section. Ask your care team to verify care below or attach a confirmation.

Patient full name

Date of birth MM/DD/YYYY

Cancer care clinic or hospital

Treating doctor / care-team contact

Clinic phone

Social worker / navigator name and phone

Current care status - check what applies.

- ☐ Treatment planned
- ☐ Receiving treatment
- ☐ Follow-up / survivorship
- ☐ Palliative / hospice care
- ☐ Other care status
- ☐ Unsure

Next cancer-care appointment date if known

Treatment schedule if travel help is needed

Insurance coverage - check all that apply.

- ☐ Medicare
- ☐ Medicaid
- ☐ Private insurance
- ☐ VA / military
- ☐ Uninsured
- ☐ Coverage pending
- ☐ Other

Insurance company or plan name

Plan customer service phone if known

Do not include full insurance member numbers in this application. Provide billing details directly to staff only if needed to arrange assistance.

Cancer-care confirmation by the care team

A treating clinician, clinic staff member, nurse navigator or oncology social worker may complete this section. A current clinic letter confirming cancer care may be attached instead. Do not attach a full medical record.

- ☐ Care team completes below
- ☐ Confirmation letter attached

I confirm that the patient named above is receiving, has received, or is scheduled for cancer-related care through the clinic or service identified here.

Cancer diagnosis / type if needed for eligibility

Diagnosis month and year if known

Verifying professional name and title

Clinic / organization

Direct work phone

Date verified MM/DD/YYYY

Professional signature or typed name

Rent assistance

Complete only if requesting rent help. Copy this page for another rental request.

Patient full name

Date of birth MM/DD/YYYY

Rental address including apartment or unit

Name on the lease

Relationship to patient if different

Lease start date

Lease end date or month-to-month

Landlord / property management name

Landlord phone

Landlord business email or office address

Monthly rent $

Current unpaid balance $

Amount requested $

Rent months or dates needing payment

Payment deadline

Current situation - check all that apply.

- ☐ Rent past due
- ☐ Notice received
- ☐ Court / eviction date set

Notice date

Court / eviction date if shown

Late fees included $

Help pledged by another source $

Amount household can pay $

Payee name exactly as listed by landlord

Attach proof for this request

- ☐ Signed lease / rental agreement
- ☐ Current rent statement or ledger
- ☐ Late / eviction notice if received
- ☐ Proof of other payment pledges if any

The lease should show the tenant, property address, rent amount and signatures. The balance statement should show the months owed, fees and total due. If no written lease is available, explain on page 11 and provide landlord contact information.

Staff will confirm the balance and payment instructions with the landlord before arranging any approved payment.

Utility assistance

Complete one page per utility provider. Copy this page for additional utility bills.

Patient full name

Date of birth MM/DD/YYYY

Utility type - check what applies.

- ☐ Electric
- ☐ Gas / heating fuel
- ☐ Water / sewer
- ☐ Trash service
- ☐ Other essential utility

Utility company / provider

Provider phone

Service address

Account holder name

Relationship to patient if different

Account number as shown on bill

Billing period

Current bill $

Past-due amount $

Total balance $

Amount requested $

Bill due date

Disconnect date if shown

Service status - select one.

- ○ Active
- ○ Disconnect notice
- ○ Already disconnected

Amount provider requires to prevent shutoff or restore service $

Reconnect fee if included $

Help pledged by another source $

Amount household can pay $

Payment arrangement or provider reference number if any

Attach proof for this request

- ☐ Current bill with account and balance
- ☐ Disconnect notice if received

Include the bill page showing the account holder, service address, account number, balance and due date. Include any payment arrangement or pledge from another program. If the account is in another person's name, explain the household relationship on page 11.

Do not provide online-account passwords or bank / card information. Staff will verify the amount needed with the utility provider.

Doctor visit copay assistance

Complete one page per provider or billing office. Copy this page for another provider.

Patient full name

Date of birth MM/DD/YYYY

Doctor / provider name

Clinic / facility name

Clinic address

Billing office phone

Billing contact name if known

Insurance plan or uninsured

Patient billing account if shown on statement

List the visit dates and the amount you are responsible for paying.

Visit date	Visit / appointment type	Patient copay $	Due date

Total patient amount due $

Help from another source $

Amount requested $

Request status - check all that apply.

- ☐ Upcoming visit
- ☐ Already billed
- ☐ Payment required before visit

Earliest deadline or appointment date

Briefly explain the visit-related financial need. Do not include a detailed medical history.

Attach proof for this request

- ☐ Appointment confirmation if upcoming
- ☐ Bill or written copay estimate
- ☐ Insurance explanation of benefits if available
- ☐ Other assistance approval if any

The bill or estimate should show the patient name, provider, visit date and patient responsibility after insurance or discounts. If requesting a deductible or other charge instead of a copay, identify it on page 11 for staff review.

Prescription copay assistance

Complete one page per pharmacy. Copy this page if another pharmacy is involved.

Patient full name

Date of birth MM/DD/YYYY

Pharmacy name

Pharmacy phone

Pharmacy address

Pharmacy contact if known

Prescribing clinician

Prescription insurance plan or uninsured

A pharmacy cost printout may replace the medication table. Include only prescriptions for which assistance is requested.

Medication name or pharmacy reference	Fill / refill date	Patient cost $	Needed by

Total patient cost $

Other help / discounts $

Amount requested $

Current prescription situation - check all that apply.

- ☐ Ready for pickup
- ☐ Waiting to be filled
- ☐ Refill needed soon

Date medication supply is expected to run out if applicable

How would you receive the prescription? Select one.

- ○ Patient pickup
- ○ Authorized person pickup
- ○ Delivery requested

Pickup person or delivery needs if applicable

Attach proof for this request

- ☐ Pharmacy cost quote / copay printout
- ☐ Discount or assistance result if available

Proof should show the patient name, pharmacy, requested prescription or reference, and current out-of-pocket cost. If the price or insurance coverage is still being checked, state that on page 11. Send only pages needed for this request.

For a prescription problem that may interrupt treatment, contact the prescribing team or pharmacist while the assistance request is reviewed.

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Transportation assistance

For scheduled medical travel. Complete one page per trip or recurring route.

Patient full name

Date of birth MM/DD/YYYY

Appointment date

Appointment time

Required arrival time

Doctor / clinic and appointment type

Clinic phone

Pickup address including city, ZIP and apartment / entrance

Destination facility and full address including city and ZIP

Patient or ride contact phone

Requested pickup time

Estimated visit length

Trip type - select one.

- ○ One way to visit
- ○ Round trip
- ○ One way home

Return address if different

Return ready time or call when ready

Help requested - check all that apply.

- ☐ Ride arrangement
- ☐ Fuel assistance
- ☐ Transit fare
- ☐ Other

Estimated fare / fuel cost $

Amount requested $

Travel distance if known

Access needs - check all that apply.

- ☐ Walker / cane
- ☐ Wheelchair-accessible vehicle
- ☐ Assistance boarding
- ☐ Companion / guardian
- ☐ Child safety seat
- ☐ Other access need

Companion name / phone and number of riders

Access details or equipment needs

For repeated visits: dates / days and number of trips

Insurance ride benefit or other ride source contacted and result

Attach: appointment confirmation showing the patient, date, time and location; fare quote if available. Include receipts if asking staff to consider a completed trip. Tell staff about changes or cancellations.

This request does not reserve a ride. Staff must confirm the vehicle, pickup, return plan and any access arrangements with you.

Food assistance

Tell us what your household can safely use and how you can receive it.

Patient full name

Date of birth MM/DD/YYYY

People needing food

Children under 18

Adults age 60 or older

Date food is needed

How many days of food are needed

Requested help - check all that apply.

- ☐ Groceries / food box
- ☐ Prepared meals
- ☐ Grocery assistance
- ☐ Nutrition products prescribed by care team
- ☐ Other food need

Food allergies, medically directed food restrictions, cultural preferences or foods that cannot be used. Write none if there are no restrictions.

Food storage and preparation available - check all that apply.

- ☐ Refrigerator
- ☐ Freezer
- ☐ Stove
- ☐ Microwave
- ☐ No cooking access

How can you receive food? Select one.

- ○ Patient pickup
- ○ Authorized person pickup
- ○ Delivery requested

Pickup person name and phone if applicable

Delivery address if requested

Delivery phone and safe delivery / access instructions

Current food programs or assistance received

If requesting grocery funds: estimated cost $

Amount requested $

Supporting information for food assistance

Use the household and income information on page 3. If requesting a prescribed nutrition product, attach the care-team recommendation and a current price quote. If asking about reimbursement, attach the receipt for staff review.

Note any urgent shortage, difficulty carrying groceries, swallowing-related food needs already identified by your care team, or other food access issue on page 11.

Hardship and supporting statements

Explain your financial need here. Complete the other sections only when they apply.

Patient full name

Date of birth MM/DD/YYYY

How has cancer or caregiving affected income, work, basic expenses or access to care? What help is most urgent?

Urgent deadline and what may happen if help is delayed

Other help for the same expenses

List assistance received, approved or pending from another organization, insurer, family member or source. Write none if there is no other help.

Source / organization	Expense covered	Amount $	Received / approved / pending

Zero income declaration if applicable

☐ I currently have no personal income.

☐ No one in my household has cash income.

Date income stopped

Last income source if any

How are housing, food and other necessities being covered? List support or benefits and any expected return of income.

Person making declaration - signature or typed name

Date

Missing documents or information that needs explanation

Identify any missing proof, why it is unavailable, an expected date if known, and a person or alternate document that may verify the request. Also explain irregular income here.

Use an extra sheet for additional details. Put the patient name and the related page number on it. Missing proof should be discussed with staff; do not create or alter documents.

Checklist and applicant signature

Complete this page for every application. Keep a copy of what you submit.

Patient full name

Date of birth MM/DD/YYYY

Before submitting

- ☐ Patient and household pages completed
- ☐ Income proof or zero income statement
- ☐ Requested assistance pages completed
- ☐ Missing documents explained on page 11
- ☐ Proof of identity included
- ☐ Cancer-care confirmation included
- ☐ Relevant bills / appointment proof attached
- ☐ Other help for the same costs disclosed

Identity proof may be a photo ID or another document staff can use to confirm identity. For a child, provide patient identity information and parent / guardian identification. Discuss alternatives with staff if identification is unavailable.

Send copies through a submission method arranged with staff at **844-944-3198**. Do not provide Social Security numbers, online passwords, or full bank / payment-card numbers. Redact unrelated financial transactions and medical details.

Permission to verify and arrange requested assistance

I give Patricia Haley Charity permission to contact the parties I select below about this application. Only information needed to verify my request or arrange approved assistance may be shared, such as my identity, requested bill or cost, appointment details and travel needs.

- ☐ Landlord / utility provider
- ☐ Transportation / food provider
- ☐ Doctor / clinic / pharmacy
- ☐ Other assistance source listed

This permission is for this assistance request. My clinic may require its own authorization before releasing health information. I may contact the charity to change future contact permission; verification may then need to be completed another way.

Applicant certification

I certify that the information I provided is true and complete to the best of my knowledge. I will report changes in my request and any other payment for the same expense. I understand that assistance depends on review and available resources and is not guaranteed.

Applicant / parent / legal guardian signature or typed name

Date MM/DD/YYYY

Printed name if different from patient

Relationship / authority to sign

Helper or interpreter name if used

Phone

By entering my name in the signature field, I intend to sign this application. A parent or authorized legal guardian signs for a minor. If using a printed form, sign by hand.

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Staff review and payment record

For Patricia Haley Charity staff use only. Do not ask the patient to complete this page.

Patient full name

Date of birth MM/DD/YYYY

Application / case number

Date received

Assigned staff

Review status - select one.

○ Pending ○ Approved ○ Partially approved ○ Not approved

☐ Identity / household reviewed ☐ Income reviewed ☐ Cancer care verified

☐ Bills / payees verified ☐ Duplicate aid checked ☐ Urgency assessed

Eligibility criteria applied and funding source

Record approved financial amounts or a clear in-kind service description.

Category	Requested $ or service	Approved $ or service	Verified payee / provider
Rent			
Utility			
Doctor copay			
Prescription			
Transportation			
Food			

Total approved financial assistance $

Decision date

Decision reason, missing proof, referrals, follow-up, or service arrangements. Confirm transport access and both directions when relevant.

Reviewer signature or typed name

Approver signature or typed name

Payment / service date

Payment reference or attached ledger

Applicant notified by / date / method

Follow-up due / closed date

Attach the itemized payment log and confirmation of payment or service. Share only the details needed by the payee; do not send cancer-care documents to a landlord, utility, food or transportation provider.