# Guidelines for Financial Assistance

Financial assistance provided by The National Children's Cancer Society (N.C.C.S.) is made possible because of generous donors. It is important that these funds be available for families experiencing the greatest financial need. To apply for financial assistance, please complete the attached application. N.C.C.S. staff will contact you after your application is received.

1. Any child diagnosed with cancer on or before his/her 18th birthday and treated before his/her 21st birthday is eligible for consideration. Adults who relapse after their 18th birthday and who were not previously assisted are not eligible for services.

2. Children must be citizens or lawful, permanent residents of the U.S. who have maintained an uninterrupted residency for 12 months without prior history of the current illness. Non-citizen residents, applying for assistance, must have and provide N.C.C.S. with a photocopy (front and back) of their I551 card (green card).

3. If a family possesses liquid assets in excess of $5,000, the N.C.C.S. reserves the right to request a partial or complete spend-down prior to the approval of financial assistance.

4. All sections of the application must be completed thoroughly and accurately in order for the organization to review the request. Failure to provide complete and truthful information is a basis for denial.

5. In order to review the request for financial assistance, a hospital professional (doctor, nurse or social worker) must send a letter of support. This may be sent via facsimile, email or postal service and should include the following:
    - Child's full name, date of birth, and diagnosis
    - Past treatment information
    - Treatment plan for the next 60 days
    - Other community resources being utilized

6. Assistance may be requested for up to two months or 60 calendar days. At the end of this time if additional assistance is needed, consideration will be given to those requests submitted in writing by a hospital professional. A new application is only necessary when the length of time between requests exceeds one year.

7. Financial assistance is not retroactive. Requests cannot be processed until all information is received.

**After you complete the application, please forward it by mail or fax (314-241-1996) to:**

**The National Children's Cancer Society**
**Patient & Family Services**
**One South Memorial Drive, Suite 800**
**St. Louis, MO 63102**

**OFFICE USE ONLY**
Date Received ___________

## Personal Information – *Please PRINT and complete all sections accurately*

Patient Name (first, middle, last) ________________________ ☐ Male ☐ Female

Date of Birth ____________ Place of Birth (state/country) ________________ SS# ________________

Patient's Address ________________________________________

City/State/Zip ________________________________________

Marital status of Parents'/Guardians' ☐ Single ☐ Married ☐ Divorced ☐ Cohabitants

If divorced, who has custody of the patient/child? ________________________

**If parents/guardians do not reside in the same household and are both seeking financial assistance, both parents must fill out an application.**

Parents'/Guardians' Name(s)________________________________________

Permanent Phone # (_____)________________ Cell Phone # (_____)________________

Email ________________________________________

Is address same as patient's? ☐ Yes ☐ No If no, address________________________

City/State/Zip ________________________________________

Do parents'/guardians' speak English? ☐ Yes ☐ No If no, primary language? ________________

How did you hear about The National Children's Cancer Society? ☐ Hospital Professional ☐ Friend ☐Other__________

Emergency Contact Name (other than parent/guardian listed above) ________________________

Relationship ________________ Phone (_____)________________

## Medical Information – *This section to be completed by hospital personnel (social worker, nurse or doctor)*

**A letter from social worker, nurse or doctor explaining the child's diagnosis, family situation, and the assistance being requested is needed in addition to the completion of this section. See guidelines for necessary information.**

Name of Hospital ________________________ Patient Information # (_____)________________

Social Worker (first and last name) ________________ Phone # (_____)________________

Pager # (_____)________________ Email ________________

Mailing Address ________________ Dept. ________________

City/State/Zip ________________________________________

Name of Physician (first and last name) ________________ Phone # (_____)________________

Diagnosis ________________________ If brain tumor, grade of tumor ________

Date of diagnosis__________ Number of relapses __________ Date of relapse __________

Other treatment facility involved in child's care ________________________

Social Worker (first and last name) ________________ Phone # (_____)________________

Pager # (_____)________________ Email ________________

Mailing Address ________________ Dept. ________________

City/State/Zip ________________________________________

Patient Name ____________________

## Household Income and Assets

**Employment**

**Parent/Guardian** Net Annual
Employer ______________________________ Salary ______________

Phone # (___)____________________ Is Parent/Guardian on unpaid leave? ☐ Yes ☐ No

**Parent/Guardian** Net Annual
Employer ______________________________ Salary ______________

Phone # (___)____________________ Is Parent/Guardian on unpaid leave? ☐ Yes ☐ No

**Other Income**: SSI ____________ Child Support ____________ TANF ____________ Other____________

**Banking and Investments (Please include banking information for all accounts).**
**To expedite processing your application, please include a copy of your most recent statements for all of the accounts below. If a family possesses liquid assets in excess of $5,000, the N.C.C.S. reserves the right to request a partial or complete spend-down prior to the approval of financial assistance.*

Name of Bank ______________________________

Checking Acct.# ____________________ Savings Acct.# ____________________

Checking Acct.# ____________________ Savings Acct.# ____________________

Name of Bank ______________________________

Checking Acct.# ____________________ Savings Acct.# ____________________

Checking Acct.# ____________________ Savings Acct.# ____________________

*(Please include information for money markets, CDs, mutual funds, stocks, and other investments. Do not include IRA's or other retirement accounts.)*

Type of Account____________________ Type of Account____________________

Value ____________________ Value ____________________

Type of Account ____________________ Type of Account____________________

Value ____________________ Value ____________________

**Fundraising**
Has money been raised on behalf of the applicant? ☐ Yes ☐ No If yes, how much?____________

How much is currently in the account? ____________ Are there any restrictions on the account? ☐ Yes ☐ No

If yes, please state restrictions: ______________________________

Name of Bank ____________________ Account # ____________________

**Assistance from other organizations**
If you have applied for or received assistance from another organization, please list.

Organization____________________ Type of Assistance ____________________

Organization____________________ Type of Assistance ____________________

Organization____________________ Type of Assistance ____________________



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Patient Name ____________________

## Insurance Information

Is patient covered by private insurance? ☐ Yes ☐ No

Is patient covered by a state funded insurance plan (i.e. Medicaid)? ☐ Yes ☐ No

What is the name of the plan? ____________________

What is the percentage of coverage? __________

Address of insurance company ____________________

City/State/Zip ____________________ Phone (___)____________________

Does insurance provide assistance with meals, transportation, or lodging expenses? ☐ Yes ☐ No

Is there a secondary insurance? ☐ Yes ☐ No

If yes, what is the name of the plan? ____________________

Has the family completed an application for Medicaid? ☐ Yes ☐ No

## Non-Medical Expenses

N.C.C.S. provides financial assistance for the non-medical costs of getting a child to treatment. N.C.C.S. staff will contact you to determine how the organization can best help you with these expenses.

## Request for Assistance with Medical Expenses –

**For treatment/procedures denied by the hospital due to a lack of funding**

**N.C.C.S. does not assist with medical expenses outside of the U.S. and/or its territories.**

**Please check all that apply:**

☐ Bone Marrow Transplant ☐ Donor Search ☐ Donor Harvest

☐ Other cancer treatment procedures Specify: ____________________

☐ Pharmaceuticals/Supplies Specify: ____________________

An applicant may be eligible for assistance with medical expenses if the treatment has been denied by the hospital due to a lack of funding and the treatment is FDA approved. **N.C.C.S. does not assist with expenses already incurred, co-pays or deductibles.** If requesting assistance, please include the following with your application:

1. A letter from the physician, detailing the child's diagnosis, treatment history, and recommended procedure.
2. A letter from the hospital, detailing all costs and the hospital's official position on treating a patient without means to pay.
3. A letter of denial and a copy of the insurance policy may be requested if a procedure/treatment has been denied by Medicaid or a private insurance company.

***Note: Requests for medical assistance may be put before the N.C.C.S. Medical Advisory Board for approval. Additional information regarding assets and insurance may be requested.**

## Other Support

Please check all other N.C.C.S. services you are interested in.

☐ Online Support/Message Board ☐ Educational Programs/Materials

☐ Beyond the Cure Survivorship Program ☐ Referrals to other resources

## Important Notice Please Read:

The N.C.C.S. is a charitable organization dependent upon the public for support. The N.C.C.S. tries to maximize the limited resources available. These guidelines are a statement of the N.C.C.S.'s general policy, and the N.C.C.S. reserves the right, in its sole discretion, to modify the same at any time without notice.

You will not be discriminated against or denied aid because of your race, religion, color, national origin, sex or political affiliation.

All financial applications will be reviewed on a case by case basis and final determination will be made based upon other applications submitted and the availability of funds.

The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

## Consent to Release Information and Affirmation

I do hereby authorize all hospitals, financial institutions, and insurance groups to release to The National Children's Cancer Society, or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. In addition, I do hereby authorize all hospitals, financial institutions, and insurance groups to release to The National Children's Cancer Society, or its duly authorized representative, any information or itemized statements that pertain to bone marrow transplant and related expenses. I further authorize N.C.C.S. and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

As an inducement to The National Children's Cancer Society, a non-profit organization, to advance supplemental family support expenses in conjunction with the medical treatment of ______________________________(child) undersigned to hereby affirm as follows:

1. The undersigned are the parents or guardians of the child.
2. The term "non-medical expenses" is understood to mean those reasonable and necessary expenses incurred by the family or guardian of the above-named child in conjunction with that child receiving medical treatment. Financial assistance will be provided, with the use of said funds to be specified by N.C.C.S.
3. The undersigned further agree(s) to return any unused funds immediately to The National Children's Cancer Society so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledges(s) and agree(s) to maintain records that will be made available to The National Children's Cancer Society upon reasonable request, detailing the expenditures made from the funds provided by the organization.

The National Children's Cancer Society will pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Dated this ______________________ day of ______________ , in the year __________

| ______________________________ | ______________________________ |
|---|---|
| Mother/Guardian Signature | Father/Guardian Signature |
| ______________________________ | ______________________________ |
| Please Print Name | Please Print Name |
| ______________________________ | ______________________________ |
| Social Security Number | Social Security Number |

**Witness:** ______________________________________________

# Consent Form

I hereby give my permission for The National Children's Cancer Society (N.C.C.S.) and/or its representatives to use artwork, photographs and/or letters that I provide of my child, my family, or myself in publications, slides, videotapes, motion pictures or on the Internet. In addition, I hereby give my permission for The National Children's Cancer Society and/or its representatives to photograph, audio tape record, or videotape my child or myself and to use our names, these images or voice recordings in publications, slides, videotapes, motion pictures or on the internet.

I understand these visual images or voice recordings may be used to inform families, volunteers, donors, the media and general public about N.C.C.S. programs, services or events.

I gladly give this authorization to support the efforts of The National Children's Cancer Society. I understand this authorization shall continue until terminated in writing.

***Signing the consent form is not a requirement in order to receive assistance from The National Children's Cancer Society.***

**Please Print Clearly**

| Name/Child's Name: | | Date of Birth: |
|---|---|---|
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | Cell: | Fax: |
| Email: | | |

Signature____________________________________________Date____________________
(parent/guardian signature required for minors)

Please complete one form per participant/volunteer.

N.C.C.S. 02/08