

# Patient Assistance Foundation of Cancer Specialists of North Florida Grantmaking Guidelines

*The mission of the Patient Assistance Foundation of Cancer Specialists of North Florida is to ease the financial burden of patients in our community who are suffering from cancer or malignant blood-related diseases.*

## Foundation Purpose

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To provide short-term financial assistance for, as an example, but not limited to:

- Rent or mortgage payments;
- Basic utilities including water, sewer, electricity, or telephone;
- Basic transportation costs (taxi fare, automobile payments and/or repairs);
- Limited retail pharmacy costs;
- The foundation does not pay patient medical bills, copayments or credit card bills.

## Eligibility Guidelines

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In order to qualify, the patient must:

- Be 18 years of age or older;
- Be a current resident of Baker County (FL), Clay County (FL), Duval County (FL), Flagler County (FL), Nassau County (FL), Putnam County (FL), St. Johns County (FL), Camden County (GA), or Charlton County (GA);
- Have received treatment from an Oncologist or Hematologist for cancer or malignant blood-related disease within the past six months (*treatment is defined as receiving blood products, chemotherapy, radiation and/ or surgery*);
- Have monthly income at or below 200% of the national poverty level;
- Have no more than \$5,000 in liquid assets (*liquid assets are defined as cash, checking or savings accounts, stocks, bonds, etc.*), and no more than \$15,000 in a 401K;
- Disclose all property owned, business and rentals; this will be considered in making our final decision.
- Disclose all assistance previously received; this will be considered in making our final decision.

## 2020 Federal Poverty Guidelines

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Number per household	200% of Annual Poverty Level	200% of Monthly Poverty Level
1	\$25,520	\$2,127
2	\$34,480	\$2,873
3	\$43,440	\$3,620
4	\$52,400	\$4,367
5	\$61,360	\$5,113
6	\$70,320	\$5,860
7	\$79,280	\$6,607
8	\$88,240	\$7,353

## Grant requests may *only* be:

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- For debt incurred within the past twelve months that was incurred as a direct result of the illness;
- For patients currently in active treatment: debt above \$200 and below \$2,500 per instance, pending available funding;
- For patients who have completed treatment within the past 6 months: debt above \$200 and below \$1,000 per instance, pending available funding;
- Submitted no more than once per patient, unless there is a significant change of status based solely on diagnosis and no more than one time per six month period (maximum grant amount to be determined by the Foundation Advisory Board).

## **Application Process**

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Patients must fully complete and sign the *Grant Application* and the *Personal Statement Form*.

In addition, the following documentation is required for applications to be considered:

- Proof of patient eligibility; physician documentation of oncology or hematology malignant treatment within the past six months;
- Copy of bills to be paid (please submit photocopy of invoice to ensure grant payment attributed to the correct account);
- Photocopy of the last three months bank and/or brokerage statements for all open accounts in the household;
- Photocopy of most recent Federal Income Tax Return and W2 for all members of the household of working age;
- Photocopies of last three pay stubs;
- Social Security statements for the patient;
- Any other applicable income for each individual living in the household for the past 3 months;
- Full disclosure and copies of statements for 401k's, IRA's, HSA's, HRA's, FSA's, stocks, bonds and any other monetary assets;
- Must disclose any other grants received from other charitable organizations within the last twelve months.

*\*\*If you are unable to provide any of the above information, please explain why under the 'Additional Information' section located on the Personal Statement Form.*

## **Discretionary Foundation Guidelines**

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Exceptions to the Foundation Guidelines listed previously are possible only with the approval the Foundation Advisory Board.

Grant requests made from the fund that fall outside the Foundation Guidelines must:

- Not exceed 20% of the total distributable amount of the fund per calendar year
- Be a debt above \$200 and below \$2,500 per instance for active patients
- Be a debt above \$200 and below \$1,000 per instance for patients who completed treatment within the last 6 months.
- Be submitted no more than once only per patient
- Be exceptions of a financial nature that are directly attributable to the illness

Approval of the application is required by the Foundation Advisory Board based on review of the applicant's information and is at the discretion of the Advisory Board only. In keeping with the foundation's mission of providing short-term emergency financial aid, patients who apply multiple times must show a significant change in financial circumstances if they reapply for aid.

*Should an applicant fail to fully complete the application and required documentation, the application will be returned resulting in a delay of the application process. Applications will be kept open for a maximum of 30 days from the date the application is received. If all required documentation is not received within 30 days, the application will be closed and the applicant must wait four months to reapply.*

***Please note that the application process will take approximately two weeks from the date the Foundation receives a fully completed application.***

Please mail completed application to:

**Patient Assistance Foundation  
of Cancer Specialists of North Florida  
7015 AC Skinner Parkway, Suite 1  
Jacksonville, FL 32256  
Telephone: 904.519.2739  
Fax: 904.538.3672**



**Personal Statement**

*Please answer the following questions. The information you provide will help the Grant-making committee to better understand your needs.*

**Describe your financial need.**

*Specifically, with what bills do you require assistance?*

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**Explain the impact of your health.**

*What is your diagnosis and how has your medical diagnosis affected your ability to pay bills?*

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**Make plans for the future.**

*Understanding this assistance is only short term, what long term steps do you have in place to resolve this financial burden?*

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**Addition Information**

*Are there any documents or information missing from your application? Is there any other information you wish to share with the committee?*

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GRANT APPLICATION

Oncology Physician: \_\_\_\_\_

THIS FORM MUST BE FULLY COMPLETED

Patient Name: \_\_\_\_\_

Last

First

Middle

SS #: \_\_\_\_\_ Telephone: \_\_\_\_\_

Home

Work

Cell

Date of Birth: \_\_\_\_\_ # Living in Household: \_\_\_\_\_

Address: \_\_\_\_\_

Street

Apt #

City

State

Zip Code

Monthly Income:

Monthly Net Earnings (self): \$ \_\_\_\_\_ Past 12 Months Earnings (self): \$ \_\_\_\_\_

Monthly Net Earnings (spouse): \$ \_\_\_\_\_ Past 12 Months Earnings (spouse): \$ \_\_\_\_\_

Monthly Net Earnings/Income (other): \$ \_\_\_\_\_ Past 12 Months Earnings (other): \$ \_\_\_\_\_  
(Child Support, Alimony, Rental Income, etc.)

Explain: \_\_\_\_\_

Do you own property other than you primary residence?

Checking Account: \$ \_\_\_\_\_ Savings Account: \$ \_\_\_\_\_ 401K: \$ \_\_\_\_\_ Stocks/Bonds: \$ \_\_\_\_\_

Have you received assistance in the past 12 months from other charitable organizations, churches, etc?

If yes, total amount received: \$ \_\_\_\_\_ From Whom? \_\_\_\_\_

A. TOTAL NET MONTHLY HOUSEHOLD INCOME: \$ \_\_\_\_\_

Monthly Expenses:

Rent/Mortgage Payment: \$ \_\_\_\_\_ Phone: \$ \_\_\_\_\_ Cable: \$ \_\_\_\_\_

Electric/Gas: \$ \_\_\_\_\_ Water/Sewer: \$ \_\_\_\_\_ Food: \$ \_\_\_\_\_

Auto Payment: \$ \_\_\_\_\_ Automobile Fuel: \$ \_\_\_\_\_ Auto Ins: \$ \_\_\_\_\_

Property Ins.: \$ \_\_\_\_\_ Property Tax: \$ \_\_\_\_\_ Church Tithe: \$ \_\_\_\_\_

Life Insurance: \$ \_\_\_\_\_ Health Insurance: \$ \_\_\_\_\_ Alimony: \$ \_\_\_\_\_

Child Support: \$ \_\_\_\_\_ Other Medical Expenses: \_\_\_\_\_

Other Expenses (List): \_\_\_\_\_

B. TOTAL MONTHLY EXPENSES: \_\_\_\_\_

Applicant Statement:

I certify that all the information that I have provided in order to apply for financial assistance is true, complete and correct. I expressly authorize, without reservation, the Patient Assistance Foundation of Cancer Specialists of North Florida and its advisors or representatives to contact and obtain information from all employers, physicians, related creditors, and public agencies and to otherwise verify the accuracy of all information provided by me in this application, or financial interview. I hereby waive any and all rights and claims I may have regarding the Patient Assistance Foundation of Cancer Specialists of North Florida and its advisors or representatives for seeking, gathering and using truthful and non-defamatory information, in a lawful manner, in the application process and all other persons, corporations or organizations for furnishing such information about me. I agree that I have received a copy of and fully understand the Patient Assistance Foundation of Cancer Specialists of North Florida Guidelines. I understand that any information provided by me that is found to be false, incomplete or misrepresented in any respect will be sufficient cause to (i) eliminate me from consideration for financial assistance, and (ii) will result in the immediate denial of this application.

Do not sign until you have read the above application statement.

I certify that I have read, fully understood and accept all terms of the foregoing Application Statement.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_