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:

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, including car payments and or repairs
- Car, home, or renter's insurance expenses

****The Foundation does not pay patient medical bills, copayments, or credit card bills****

Eligibility Guidelines: ***PLEASE READ CAREFULLY***

In order to qualify for a Foundation Grant, the patient must:

- Be 18 years of age or older
- Be a current resident of one of the following counties in North Florida or South Georgia:
    - Baker (FL)
    - Clay (FL)
    - Duval (FL)
    - Flagler (FL)
    - Nassau (FL)
    - Putman (FL)
    - St. John's (FL)
    - Camden (GA)
    - Charlton (GA)
- Have received treatment from an oncologist or hematologist for cancer or malignant blood-related diseases within the past 3 months.
    - Treatment is defined as receiving blood products, chemotherapy, radiation, and/or surgery
- Have a monthly income at or below 300% of the national poverty level
- Have no more than $10,000 in liquid assets
    - Liquid assets are defined as cash, checking or savings accounts, stocks, bonds, etc.
- Have no more than $50,000 in a 401K
- Disclose all property owned, businesses, 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.

2024 Federal Poverty Guidelines: ***PLEASE READ CAREFULLY***

# in Household	300% of Poverty Level	300% of Monthly Poverty Level
1	$45,180	$3,765
2	$61,320	$5,110
3	$77,460	$6,455
4	$93, 600	$7,800
5	$109,740	$9,145
6	$125,880	$10,490
7	$142,020	$11,835
8	$158,160	$13,180

Approved/Effective: 10.3.2024

Grant Requests May Only Be:

- For debt incurred within the past 12 months that was incurred as a direct results of the illness
- For patients currently in active treatment
    - Debt above **$200** and below **$3,000**, pending available funding
- For patients who have completed treatment within the past 3 months:
    - Debt above **$200** and below **$3,000**, 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 6-month period
    - Maximum grant amount to be determined by the Foundation Advisory Board

Application Process: ***PLEASE READ CAREFULLY***

Patients must fully complete and sign the ***Grant Application***, ***Personal Statement & Bill Request, and Proof of Diagnosis*** form.

In addition, the following documentation is **required at the time of submission** for applications to be considered:

- Current photocopies of bills and/or invoices to be paid
- Photocopies of the last 3 months of bank and/or brokerage statements for all open accounts of household members
- Photocopies of most recent Federal Income Tax Return and W2 for all household members of working age
- Photocopies of last 3 paystubs
- Social Security and/or Disability award letters/statements for patient and all household members, if applicable
- Any other applicable income for all household members of working age for the last 3 months
- Full disclosure and copies of statements for 401Ks, IRAs, HSAs, HRAs, FSAs, stocks, bonds, and any other monetary assets
- Full disclosure of any other grants received from other charitable organizations within the last 12 months.

If you are unable to provide any of the above information, please explain why under the "Additional Information" section locations on the **Personal Statement & Bill Request form**

Discretionary Foundation Guidelines:

Exceptions to the Foundation Guidelines listed previously are possible only with the approval of 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 $3,000 per instance for active patients
- Be a debt above $200 and below $1,500 per instance for patients who have completed treatment within the last 3 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 direction 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 diagnosis to 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 documents are not received within 30 days, the application will be closed and the applicant must wait 3 months to reapply. If the applicant is denied for any reason, they must wait six months to reapply.

Please note that the application process will take approximately three weeks from the date the Foundation Advisory Board receives a fully completed application until potential approval and payment.

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Please return completed application to your Oncology Social Worker

Only fully completed applications with all supporting documents as outlined on pages 1 and 2 will be processed.

Social Workers: Please return completed applications to

Mail to:
Patient Assistance Foundation
Attn: Brenna St Pierre
7015 AC Skinner Pkwy
Suite 1
Jacksonville, FL 32256

OR

Fax to:
904.538.3672

OR

Email to:
Pafcsnf@CSNF.us

THE FOLLOWING APPLICATION MUST BE COMPLETED IN ITS ENTIRETY AND SUBMITTED WITH ALL SUPPORTING DOCUMENTATION AS LISTED ON THE ABOVE PAGE OR YOUR APPLICATION WILL NOT BE CONSIDERED.

THIS FORM MUST BE FULLY COMPLETED AND RETURNED WITH ALL SUPPORTING DOCUMENTATION OR APPLICATION _WILL NOT BE CONSIDERED_

GRANT APPLICATION

Oncology Group: ____________________

Patient Information:

Patient Name: ____

SS #: ______________________ **Date of Birth:** ________________ **Phone:** ____________________

Address: ____

____ **# Living in Household:** __________

Monthly Income & Assets:

Monthly Net Earnings (Self): $ ____________________ **Past 12 Months Earnings (Self):** $ ____________________

Monthly Net Earnings (Partner/Spouse): $ ____________ **Past 12 Months Earnings (Partner/Spouse):** $ ____________

Monthly Net Earnings (Other*): $ ____________________ **Past 12 Months Earnings (Other):** $ ____________________

*Other is defined as child support, alimony, rental income, etc.)

Explain other: ____

Do you own property other than your primary residence? ____________________________

Checking Account: $ __________ **Savings Account:** $ __________ **401K:** $ __________ **Stocks/Bonds:** $ __________

TOTAL NET MONTHLY HOUSEHOLD INCOME: $________________

Additional Assistance Disclosure:

Have you received assistance in the past 12 months from any other charitable organizations, churches, etc.? **Yes** or **No**

If yes, total amount received: ________________________ **From whom?** ____________________

Monthly Expenses:

Rent/Mortgage:	$ ____________	Life Insurance:	$ ____________	Property Tax:	$ ____________
Utilities:	$ ____________	Child Support:	$ ____________	Health Insurance:	$ ____________
Auto Payment:	$ ____________	Phone:	$ ____________	Cell Phone:	$ ____________
Property Ins:	$ ____________	Auto Fuel:	$ ____________	Other Medical:	$ ____________
Cable:	$____________	Auto Ins.:	$ ____________	Alimony:	$ ____________
Food:	$____________	Church Tithe:	$ ____________		

Other Expenses: ____

TOTAL MONTHLY EXPENSES: $________________

Application 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 no-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.

Name: ____ **Date:** ____________________

Patients must sign their own application, unless someone has been appointed as medical proxy.

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THIS FORM MUST BE FULLY COMPLETED AND RETURNED WITH ALL SUPPORTING DOCUMENTATION OR APPLICATION *WILL NOT BE CONSIDERED*

PERSONAL STATEMENT & BILL REQUEST

Please answer the following questions fully and to the best of your ability

1. **Explain the impact your medical diagnosis has had on your ability to pay bills:**

____

____

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

____

____

3. **Which bills do you need assistance in paying*?**
*Providing information does not guarantee bill payment. Please indicate your three most-needed payments.

Rent or Mortgage:
Payment address: ______________________
____
Account number: ______________________

Home Insurance:
Payment address: ______________________
____
Account number: ______________________

Auto Loan:
Payment address: ______________________
____
Account number: ______________________

Auto Insurance:
Payment address: ______________________
____
Account number: ______________________

Cell Phone:
Payment address: ______________________
____
Account number: ______________________

Utilities:
Payment address: ______________________
____
Account number: ______________________

Other:
Payment address: ______________________
____
Account number: ______________________

Other:
Payment address: ______________________
____
Account number: ______________________

4. **Are there any documents or information missing from your application? Is there anything you'd like to share with the committee?**

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PROOF OF DIAGNOSIS

Patient Information:

Patient Name: ____

Last 4 Digits of Social Security Number: _________________________________ **Date of Birth:** _______________________________

Physician/Oncologist Information:

Name of Treatment Center: _______________________________ **Name of Physician:** ______________________________________

Address of Treatment Center: ____

Phone Number: _______________________________ **Name of Social Worker/Case Manager:** ________________________________

Diagnosis Information:

Cancer Diagnosis: _______________________________________ **Date of Diagnosis:** ____

Has the patient undergone surgery for cancer? Yes: _________ No: _________ If Yes, Date of Surgery: _______________________

Treatment Information:

Is the patient listed above currently undergoing active cancer treatment? Yes: ______ No: ______

If yes, please complete the following:

Current Treatment: Chemotherapy: __________ Immunotherapy: __________ Radiation: __________ Other: ______________

Drug Name: ________________________________ **Start Date:** _________________ **Projected End Date:** _______________________

Radiation Treatment: ________________________ **Start Date:** _________________ **Projected End Date:** _______________________

If no, please complete the following:

Date of Last Treatment: ___________________________ **Type of Treatment:** ____

Social Worker/Case Manager Signature: ____ **Date:** _______________

Patient Signature: ____ **Date:** _______________

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