

**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.

2025 Federal Poverty Guidelines: PLEASE READ CAREFULLY

# in Household	300% of Poverty Level	300% of Monthly Poverty Level
1	\$46,950	\$3,912
2	\$63,450	\$5,287
3	\$79,950	\$6,662
4	\$96,450	\$8,037
5	\$112,950	\$9,412
6	\$129,450	\$10,787
7	\$145,950	\$12,162
8	\$162,450	\$13,537

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.

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.**

GRANT APPLICATION

Patient Information:

Oncology Group: _____

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.

Approved/Effective: 1.16.2025

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?**



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

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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