The Foundation of Cancer Specialists

d/b/a The Patient Assistance Foundation

Transportation Grantmaking Guidelines

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

SECTION I: Transportation Grant Purpose

To provide transportation grants to assist with cost of transportation while eligible patients are **undergoing radiation treatments.**

SECTION II: Eligibility Guidelines

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);
- Patients must show proof of current radiation treatment from a ***Radiation Oncologist***
- Have monthly income at or below 300% of the national poverty level;
- Disclose all assistance previously received; this will be considered in making our final decision.

SECTION III: 2026 Federal Poverty Guidelines

# in Household	300% of Poverty Level	300% of Monthly Poverty Level
1	$47,880	$3,990
2	$64,920	$5,410
3	$81,960	$6,830
4	$99,000	$8,250
5	$116,040	$9,670
6	$133,080	$11,090
7	$150,120	$12,510
8	$167,160	$13,930

SECTION IV: Grant Award Amounts

- ***For patients relying on personal automobile transportation***, grant amounts are based on patients number of treatments and the distance they must travel:
  - 0-50 miles per day, patient will receive $50.00 gas card per week through the course of radiation treatment
  - 50-100 miles per day, patient will receive $75.00 gas card per week through the course of radiation treatment
  - 100+ miles per day, patient will receive $100.00 gas card per week through the course of radiation treatment
- ***For patients relying on Uber/Lyft transportation***, grant amounts are fixed and patients will receive one gift card per week of radiation treatment:
  - Patients will receive $100 Uber/Lyft gift card per week of radiation treatment
- ***For patients relying on Jacksonville Transportation Authority services***, grant amounts are fixed and patients will receive one gift card per week of radiation treatment:
  - Patients will receive $25 JTA voucher per week of radiation treatment
-

- In keeping with the Foundation's mission to provide short-term emergency financial assistance, patients who have previously received assistance are eligible to reapply **only if** they have received a **new primary cancer diagnosis or experienced a one-time progression of metastatic disease.** Additionally, at least six months must have elapsed from the date of their initial application approval before a subsequent application may be submitted.
    - Maximum grant amount is to be determined by the Application Review Committee.

SECTION V: Application Process

Patients must fully complete and sign the ***Financial Interview***, ***Medical Information + Personal Statement***, and ***Application Statement*** below.

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

- Proof of patient eligibility; physician documentation of current radiation treatment.
- Photocopies of last pay stub or other proof of income.
- Any other applicable income for each individual living in the household for the past three months.
- Must disclose any other grants received from other charitable organizations within the last 12 months.

SECTION VI: Gift Card Distribution

Patients approved for the transportation grant will receive gift cards. Gift cards can be obtained in one of the following ways:

1. Patients may pick up gift cards at ***7751 Belfort Pkwy, Suite 350, Jacksonville, FL 32256***, on Wednesdays and/or Fridays from 8:00 am to 11:00 am.

2. Approved patients' treatment centers may cover the cost of courier delivery from the Foundation's office at ***7751 Belfort Pkwy, Suite 350, Jacksonville, FL 32256***, to their office.

    a. Gift cards may be couriered in bulk and must be received by the patients' social worker.
    b. The signed acknowledgment receipt sheet must be returned to the Foundation's office by courier.
    c. Once all gift cards have been distributed, the social worker must scan and email the signed gift card receipt form to pafcsnf@csnf.us

The following should be noted:

- Gift cards cannot be mailed
- Patients will be notified via email or mail of their approval

Please return completed application to your oncology social worker.

Social Workers: Please submit completed applications using one of the following methods:

Mail
Patient Assistance Foundation
Attn: Karen Berman
7751 Belfort Pkwy
Suite 350
Jacksonville, FL 32256

Email:
Cancer Specialists of North Florida applicants:
foundation@CSNF.us
All other applicants:
pafcsnf@CSNF.us

The Foundation of Cancer Specialists
Support Through Treatment

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

FINANCIAL INTERVIEW

Oncology Group: _____

Patient Information:

Patient Name: _____

SS #: _____ **Date of Birth:** _____ **Phone:** _____

Address: _____

_____ **# Living in Household:** _____

Monthly Income:

Monthly Net Earnings (Self): $ _____

Monthly Net Earnings (Partner/Spouse): $ _____

Alimony, *if applicable:* $ _____

Child Support, *if applicable:* $ _____

Family/Friend Support, *if applicable*: $ _____

Any Additional Income, *if applicable*: $ _____

Explain Additional Income:

_____

_____

TOTAL NET MONTHLY HOUSEHOLD INCOME: $_____

Total Assets:

Do you own property other than your primary residence? Yes: _____ No: _____

Do you have a savings account? Yes: _____ No: _____

Do you have any type of retirement accounts? Yes: _____ No: _____

Please list the current totals in the following accounts. If not applicable, write "N/A"

Checking: $ _____ **Savings:** $ _____ **Retirement:** $ _____ **Stocks/Bonds:** $ _____

The Foundation of Cancer Specialists
Support Through Treatment

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

MEDICAL INFORMATION + PERSONAL STATEMENT

Medical Information:

Radiation Oncologist: _____ **Clinic Name:** _____

Date of Diagnosis: _____ **Primary Cancer:** _____ **Current Stage:** _____

First Date of Radiation Treatment: _____ **Expected End Date:** _____

Duration of Treatment in Weeks: _____ **Round Trip Mileage:** _____

Patient Transportation Information:

Does patient have reliable, daily transportation?

Yes, myself: _____ **Yes, a friend/family member:** _____ **No:** _____

Personal Statement:

1. **Are there any documents or missing information from this application?**

_____

_____

_____

_____

2. **Is there any other information you would like the Application Review Committee to know?**

_____

_____

_____

_____

The Foundation of Cancer Specialists
Support Through Treatment

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

APPLICATION STATEMENT

Please sign and initial all designated areas throughout this page to acknowledge that you have read, understand, and agree to the information, policies, and requirements outlined.

1. I certify that all the information that I have provided in order to apply for financial assistance is true, complete and correct.

_____
Initials

2. I expressly authorize, without reservation, The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation 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.

_____
Initials

3. I hereby waive any and all rights and claims I may have regarding The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation 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.

_____
Initials

4. I agree that I have received a copy of and fully understand The Foundation of Cancer Specialists d/b/a The Patient Assistance Foundation guidelines as written on Pages 1 – 3 of this application.

_____
Initials

5. 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.

_____
Initials

6. I understand and agree that meeting the eligibility guidelines as outlined in **Section II** does not guarantee approval of and distribution of grant.

_____
Initials

OPTIONAL: By initialing below, I am indicating that someone else completed this application on my behalf. I have reviewed information they have provided and agree that is a true and factual representation of what I would like to share with The Foundation regarding my current situation.

_____
Initials

Please indicate which form of communication you prefer: Mail: _____ Email: _____

If you selected email, please write it here: _____

By signing below, I certify that I have read, fully understand, and agree to all terms and conditions outlined in this application and the Foundation's Grantmaking Guidelines. I acknowledge and agree to comply with all requirements and parameters established by the Foundation. I further understand and acknowledge that all decisions made by the Application Review Committee are final.

Signature: _____ **Date**: _____

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