Oneida Health Foundation
Financial Assistance Application Form

Which fund are you applying for?

___ Cancer Care Fund (All Forms of Cancer) ____Laurie's Legacy Fund (Breast Cancer)

___ Both

Date of Application: ____

Referral to Application: ____

Applicant Name (First & Last Name):_____________________________________

County that you reside in: ____

Mailing Address: ____

City, State & Zip Code: _______________________ Phone #:____________________

E-mail Address: ____

What is your cancer diagnosis? ____

When were you diagnosed? ____

Name of Medical Provider/Hospital: ______________________________________

Office Address, City, State, Zip: ____

Phone # for the office: ___________________________

Contact Name: ________________________________

Fill out the remainder information is for the Laurie's Legacy Fund Only:

Do you have medical insurance? ____Yes ____No

If so, what insurance carrier(s)? ___________________________ Group/Policy #: _____________________

Do you have an annual deductible? ____Yes ____No If so, what is the deductible amount? ___________

Annual household income*:____________________________ # of people in the household: ___________

(*Annual household income is considered all income from work or benefits for the entire household.)

(Proof of household income needed – See acceptable documents)

Are you currently working? _____Yes _____No If so, are you working: ____Part-Time ____Full-Time

Have you lost time from work due to your diagnosis? ____Yes _____No

Amount of Financial Request: _______________________

Reason for your request: ____

Any special circumstances that we should be aware of? ____

____

Have you received assistance from Cancer Care Fund or Laurie's Legacy Fund in the past? ________

If Yes, when? _____________________ How much ($$)? _____________________

Please Note that our financial assistance priorities are as follows, in order of importance:
Medical bills not paid by insurance, prescription drugs (related to cancer diagnosis), health insurance premiums and supplemental insurance premiums, medical garment & apparatus, transportation to medical appointments, groceries and nutrition, wigs, non-medical necessary living expenses (while in active treatment).

The Funds cannot pay for any of the following:
Tax bills of any kind, vendor bills which are less than $10, auto payments, payments are more than 1 month behind, premium cable bills items (such as pay-per-view or movie rentals), auto insurance, household repairs not related to health/safety, legal fees, DMV fees, late fees, water bills, security deposits, and family member medical bills.

List of Acceptable Proofs of Income

- Copy of the most recent Federal Income Tax filing
- Copy of Unemployment Insurance Benefit letter
- Copy of Disability or Workman's Compensation Benefit Letter
- Copy of Medicaid/Social Services Cash Assistance Benefits Statement
- Copy of Social Security (SSI/SSD) Benefits Statement
- Copy of Retirement Funds/Annuity Statement
- Most recent paystubs (60 days) of all in the household
- 1099 Statements for Self-Employment

I understand that the Oneida Health Foundation will keep any information provided in extreme confidence, at all times. This statement covers medical status, personal or family life, and opinions expressed by myself and/or my family members. Limitations to this policy are the following: suspected child abuse and neglect, dangerousness to self/others, cognitive impairment resulting in an inability to adequately care for myself.

In connection with this application, I hereby authorize my health care providers to disclose to Oneida Health Foundation (as the "funder") the specific information requested on this form. This is for the purpose of determining my eligibility for the assistance I am seeking. I agree that any of my healthcare providers may rely on a copy of this authorization once signed below. I understand that once my personal health information is received by any of the Funder, its confidentiality is no longer protected under Federal Law. However, the Funder will not re-disclose this information to any other party.

All information compiled within this application is honest and completed to the best of my ability, based on true and accurate information.

Signatory Information of Applicant:

Applicant Signature: ____________________________________ Date: __________________________

Applicant Printed Name: ____

If this application is filled out by another individual, please indicate the following:

Name of Individual Applying: ____

Relationship to the Applicant: ____

Reason Applicant is unable to apply: ____

Please return this completed form with proof of income for the entire household to:

Oneida Health Foundation
321 Genesee St.
Oneida, New York 13421
or via email at
foundation@oneidahealth.org

Completion of this application *does not* indicate approval. The Oneida Health Foundation will notify you regarding the outcome. All documentation must be completed and provided to be reviewed for assistance.

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The Cancer Care Fund would not be possible without generous donations of third-party community events, such as Mom Prom, in addition to individual contributions from the community-at-large. Laurie's Legacy is provided through a generous grant provided St. Agatha's Foundation.