West Central Georgia
Cancer Coalition

The "Neighbors Helping Neighbors" Cancer Assistance Fund has been established to assist individuals or families with personal illness that have currently been diagnosed with cancer. Our goal is to provide basic necessities that patients cannot afford ***temporarily*** due to their illness.

Eligibility

You may be eligible for assistance through the "Neighbors Helping Neighbors" Cancer Assistance Fund if you meet the following criteria:

- Household income has decreased due to a cancer diagnosis in the family OR household expenses have increased due to a cancer diagnosis in the family
- Applicant resides within Talbot County
- Application is submitted with a healthcare provider's letter - see application process below

Covered Expenses/Types of Assistance

- Payments for household bills (i.e. utilities, rent/mortgage, property taxes and car payments or repairs...)

Copies of all recent statements and bills to be paid and a letter from your healthcare provider MUST accompany the application and must be turned in by the 5th of every month in order to be processed for that month. **If the application packet is not turned in by the 5th deadline then it will be processed in the next month.**

- Gift cards for groceries or gas from Walmart
  (Based on funding availability)

- Prescription Assistance

- Out of town lodging required for treatment

Under no circumstances will checks be issued directly to an individual applicant. Payments will only be made directly to creditors, landlords, utility companies, financial institutions, etc.

Once approval is given, the applicant is responsible and or required to contact their creditors, landlords, etc. to provide status of their pending assistance through the Neighbors Helping Neighbors Cancer Assistance Fund.

Limitations

Once a request is approved, the individual will not be eligible to submit another request.

The "Neighbors Helping Neighbors" Cancer Assistance Fund does not cover the following expenses:

- **hospital and doctor bills**

- **house phone or cell phone**

- **cable**

- **credit cards**

- **loan companies**

- **and other bills as determined by the allocations committee**

Limitations to the coverage are subject to change based on availability of funds. Always use the most up-to-date application and check for any changes in coverage area or coverage limitations.

Revised June 4, 2015

"Neighbors Helping Neighbors" Cancer Assistance Fund Referral Process

A request for assistance should be submitted to "Neighbors Helping Neighbors" Cancer Assistance Fund by a physician, nurse, community advocate, or other healthcare professional (the referral source).

The application is available on the ***West Central Georgia Cancer Coalition*** website (www.wcgcc.org), complete the application and proof read it to ensure all expenses fall within our guidelines.

Attach copies of all recent bills and statements. If current bills are not attached, the application *WILL NOT* be processed. A complete application packet (application, current bills and provider letter) must be turned in by the 5th of every month in order to be processed for that month. If the application packet is not turned in by the 5th deadline then it will be processed in the next month.

The application must be signed by the applicant AND the referral source.

Applications must be submitted by the following:

- FAX entire application including bills to **706-660-1829**
- E-mail the entire scanned application to admin@wcgcc.org
- Mail to **633 19th Street, Suite B, Columbus, GA 31901**

The Allocations Committee DOES NOT meet on a regular schedule; therefore, we encourage you to submit your request one month in advance.

If you would like to apply for assistance from "Neighbors Helping Neighbors" Cancer Assistance Fund, please contact your healthcare provider. If you or your healthcare provider has any questions, please call 706-660-0317.

Revised June 4, 2015

Once we receive and review your application, you will receive a phone call to verify your information and eligibility.

"NEIGHBORS HELPING NEIGHBORS"
CANCER ASSISTANCE FUND APPLICATION

Name:	
Date of Birth:	
Address:	
City:	
County:	
State:	
Primary Phone:	
Alternate Phone:	
Email Address:	
	Have you or your family member been diagnosed with Cancer?
	Yes ☐ No ☐
Date of Diagnosis:	
Primary Care Physician:	
Primary Care PhysicianAddress:	
Physician's Phone:	
Oncologist:	
Oncologist Address:	
Oncologist Phone:	
Surgeon:	
Surgeon Address:	
Surgeon Phone:	

	Type of Assistance Requested:
	(Please circle)
	Travel/Lodging
	Medical Assistance/Cobra:
	Utilities:
	Other household expenses: Rent Mortgage Assistance Property taxes
	Car Payments Car Repairs

Income & Assets:	
Total Annual Household Income:	
Total number of people in household:	
Total household Assets (excluding 401K retirement funds:	
Total household liabilities/ expenses:	
Primary Insurance provider:	
Secondary Insurance provider:	
	Any special circumstances you would like us to be aware of:

	Please tell us how you heard about our "Neighbors Helping Neighbors" fund:
	Search Engine/WCGCC website
	Friend/Relative
	Print Ad
	Facebook
	Other (please specify)
	Please read the following information carefully before signing:
	I hereby understand and recognize that the "Neighbors Helping Neighbors" Cancer Assistance Fund (the "Fund") is part of the West Central Georgia Cancer Coalition, a Georgia nonprofit corporation which is a tax exempt organization pursuant to Internal Revenue Code Section 501 (c) (3). The Fund has been established for the benefit of those people diagnosed with cancer and to provide financial assistance and/or selected or related items in support of an individual's physical and emotional well being. The Fund will provide assistance on an equal opportunity basis and without regard to an applicant's sex, race, color, religion, creed, ethnicity, marital status or sexual orientation. However, the Fund is only authorized to provide assistance to those individuals who live within the Service Area, as set forth in the Service Area section and have a current diagnosis of cancer and in need of financial assistance.
	Accordingly, I hereby certify that the financial information set forth on this application concerning my annual household income, assets liabilities and insurance provider is true and accurate, and that the purchase of goods and services that I have requested of the Fund to purchase on my behalf or family member cannot be purchased by me and my family without incurring financial hardship. I further certify that I have been diagnosed with cancer, I understand that if any of the information set fort above is false, I am subject to punishment.
Patient Signature:	
Date:	
Referring Provider Signature	
Date:	
	By typing in my signature above, I hereby grant and give permission for representatives of the Fund to contact my physician(s) as needed.

WEST CENTRAL GEORGIA
CANCER COALITION

633 19th Street
Suite B
Columbus, GA 31901

Authorization to Release Information

Applicant's Name: ____

Date of Birth: ____

Applicant's Account/Reference Number: ______________________________

I hereby authorize *West Central Georgia Cancer Coalition* to:

_____ obtain from the following _____ release to the following

Name/Business Name:

1. ____________________ 2. ____________________

3. ____________________ 4. ____________________

5. ____________________ 6. ____________________

The following documents/information from the records pertaining to services received.

Date of Service: ____________________

The records are required for the specific purpose of:

____

I understand that any information released to the *West Central Georgia Cancer Coalition* will be handled confidentially in compliance with all applicable federal laws.

I have read and understand the nature of this release.

______________________________________ ____________
Signature of Applicant/Applicant's Designated Representative Date

______________________________________ ____________
West Central Georgia Cancer Coalition Date

Revised March 22, 2016