West Central Georgia
Cancer Coalition

"Neighbors Helping Neighbors" Cancer Assistance Fund Checklist:

All items must be included with application:

- ☐ Picture Id
- ☐ Authorization for Release of Information form
- ☐ Healthcare provider letter confirming diagnosis, current treatment and any other previous financial assistance.
- ☐ Current bills (past due bills must be within period of start of diagnosis)
- ☐ Proof of income (paystubs if employed **and** employed income verification from your local Department of Labor may be required)
- ☐ Proof of residency-current utility bill in the name of applicant (spouse and/or caregiver)
- ☐ Rental agreement/lease and **NOTARIZED** letter of current circumstances (only for request of rental assistance)
- ☐ Interview is required before application is submitted to committee (once application is completed WCGCC staff will set up interview date & time)

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West Central Georgia
Cancer Coalition

The "**Neighbors Helping Neighbors**" Cancer Assistance Fund has been established to assist individuals or families that have currently been diagnosed with cancer and currently in treatment. Once treatment is completed you are not eligible to apply for assistance. Proof of treatment must be documented from your healthcare provider. 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 must reside within our 13 county region (*Chattahoochee, Harris, Marion, Meriwether, Muscogee, Schley, Stewart, Talbot, Taylor, Troup,* and *Webster* Counties, and *Lee* and *Russell* counties in Alabama.)
- Application is submitted with a healthcare provider's letter - see application process below

Covered Expenses/Types of Assistance include:

- Payments for household bills (i.e. utilities, rent/mortgage, property taxes, transportation assistance (ride to treatment) and/or gas cards...)

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 last Friday of every month in order to be processed for that month.

- Gift cards for groceries or gas from Walmart **(Based on funding availability)**
- Prescription assistance
- Out of town lodging required for treatment

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Under no circumstances will checks be issued directly to an individual applicant. Payments will only be made directly to creditors, notarized letter from landlords, utility companies, financial institutions, etc. For letters from landlord you must have a lease agreement included.

Once approval is given, the applicant is responsible and 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. Due to our limited funding, this is a one-time assistance, even if there is a reoccurrence of a different cancer.

The NHN Cancer Assistance Fund does not cover the following expenses:

- hospital and doctor bills
- house phone or cell phone
- cable
- credit cards
- loan companies (outside of mortgage 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.

"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.

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Attach copies of ALL RECENT bills and statements that you are requesting assistance. If current bills are not attached, the application *WILL NOT* be processed. A complete application packet (application, current ID/ driver's license, current bills and provider letter) must be turned in by the last Friday of every month in order to be processed for that month. If the application packet is not turned in by the deadline then it will be processed in the next month.

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

Applications can be submitted by the following:

- FAX entire application including bills to **706-660-1829**
- E-mail the entire scanned application to cancerassistancefund@wcgcc.org
- Mail to **3100 Gentian Blvd., Suite 007D 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 or case manager at the treatment facility. If you or your healthcare provider has any questions, please call 706-660-0317.

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WEST CENTRAL GEORGIA
CANCER COALITION

3100 Gentian Blvd., Suite 007D Columbus, GA 31907

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

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WEST CENTRAL GEORGIA
CANCER COALITION

"NEIGHBORS HELPING NEIGHBORS"
CANCER ASSISTANCE FUND APPLICATION
All sections below must be completed

Name:	
Date of Birth:	
Address:	
City:	
County:	
State and Zip Code:	
Primary Phone:	
Alternate Phone:	
Email Address:	
	Have you or your family member had a current diagnosis of cancer and currently in treatment?
	Yes ☐ No ☐
Date of Diagnosis:	
Primary Care Physician:	
Primary Care Physician Address:	
Physician's Phone:	
Oncologist:	
Oncologist Address:	
Oncologist Phone:	
Surgeon:	
Surgeon Address:	
Surgeon Phone:	

	Type of Assistance Requested:
	(Please circle or specify)
	Travel/Lodging
	Medical Assistance-Cobra (only):
	Utilities:
	Other household expenses: Rent Mortgage Assistance Property taxes
	Transportation Assistance Gas Card Groceries

Income & Assets:	
List Sources of Household Income: (If N/A; how are you being supported?)	
List age and persons in household:	
List household Assets (excluding 401K retirement funds:	
List household expenses/ bills:	
Primary Insurance provider:	
Secondary Insurance provider:	
	***Any special circumstances you would like us to be aware of:**
	Example: How has your household finances decreased to require a request for financial assistance?
	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 currently in treatment and in need of financial assistance. Once all required documents are received and the decision is made, you will receive an approval or declination letter regarding your eligibility.
	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 forth above is false, I am subject to punishment. **I am aware that I can only apply for financial assistance from the Neighbors Helping Neighbors cancer fund once.**
Patient Signature:	
Date:	
Referring Provider Signature	
Date:	
	By providing my signature above, I hereby grant and give permission for representatives of the WCGCC to contact my physician(s) or creditors as needed to assist with my financial hardship.