Guidelines for Financial Assistance

1. A cancer patient with a life-threatening medical condition is potentially eligible for a gift of financial assistance which will facilitate the quality of life for the patient and their family.

2. A gift must directly benefit the patient and his/her family by assisting with medical expenses, daily living, and travel expenses as they need to keep their daily life as normal as possible.

3. Financial assistance provided by Scare Away Cancer is made possible because of generous donors. It is important that these funds be available for families and individuals experiencing the greatest financial need. There is no income limit but we want to help those in the greatest of need that are unable to do so on their own. Each application is looked at individually.

5. Preferential consideration may be given to applicants residing in the Omaha-Lincoln-Council Bluffs area, however, we do accept applications from Nebraska and eastern Iowa.

6. All sections of the application must be completed thoroughly and accurately in order for Scare Away Cancer to review the request. Failure to provide complete and truthful information is a basis for denial.

7. Financial assistance is not guaranteed and is subject to the availability of funds.

8. All financial applications will be reviewed on a case-by-case basis. Considerations are taxable income, the number of family members in the household, and geographic location. Higher consideration may be given to a patient where the impact of the disease affects children in the family.

9. The information you provide to us will be held in confidence and used only in appropriate ways consistent with the reasons for which it was provided.

To apply for financial assistance, please complete the attached application.

The completed application should be:

Emailed to: angie.danaher@mclconstruction.com or info@scareawaycancer.org
or
Mailed to: Angie Danaher
Scare Away Cancer
14558 Portal Cir
La Vista NE 68138-3501

Today's Date: _____

APPLICATION

Please print all information clearly when completing the application.

PATIENT INFORMATION

First Name:	MI:	Last Name:
Address:		City, State, Zip:
Phone (home): *(phone of parent or guardian if patient is a minor)*	Cell Phone:	Work Phone:
Date of Birth:	Male ☐	Female ☐
If patient is a minor (under 18), name(s) of parent(s) or guardian(s):		
Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Cohabitate ☐ Widow(er) ☐		

MEDICAL INFORMATION *(This section must be completed by your oncology nurse, doctor, or hospital patient navigator or social worker.)*

Date of Diagnosis:	Primary Cancer:	Current Stage:
New Diagnosis: Yes ☐ No ☐	Recurrence: Yes ☐ No ☐	Is patient in active treatment? Yes ☐ No ☐
Types of treatments received in the past twelve (12) months: Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative Care ☐ Bone Marrow/Stem Cell Transplant ☐		

HEALTHCARE PROFESSIONAL *(Oncology Nurse, Doctor, or Hospital Patient Navigator/Social Worker)*

Healthcare Professional Name:	City, State, Zip:
Hospital/Clinic:	Phone:
Address:	Email:

Healthcare Professional Signature: _____

14558 Portal Cir, La Vista, NE 68138
402-339-2221
www.scareawaycancer.org

APPLICATION

HOUSEHOLD FINANCIAL INFORMATION *(Please do not leave any information blank.)*

Are you currently: Employed ☐ Retired ☐ Student ☐ Other ☐
(parent(s)/guardian(s) if patient is a minor)

Number of immediate family members in the household:
(please list family members below)

Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:	Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:
Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:	Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:
Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:	Name: ____________________ DOB: __________________ Relationship: Spouse ☐ Partner ☐ Child ☐ Other *(please explain)*:

Monthly Household Income Sources *(please list all that apply)*

Salary:	$	Alimony:	$
Pension:	$	Child Support:	$
Social Security (retirement):	$	Unemployment:	$
Short-Term Disability:	$	Public Assistance:	$
SSI:	$	Family/Friends Support:	$
SSD (disability:	$	Other:	$

Monthly Household Expenses

Mortgage/Rent: $__________________ Is mortgage/lease in your name? ☐ Yes ☐ No, explain:		Medical Bills: Auto insurance: Childcare:	$ $ $
Utilities:	$	Gas:	$
Home/Renter's Insurance:	$	Groceries:	$
Car Payments:	$	Cell Phone(s):	$
Health Insurance:	$	Other (specify):	$
Cable/Internet/Phone:	$	Other (specify:	$

APPLICATION

How did you hear about Scare Away Cancer?

Please elaborate on your individual situation of need (tell us your story). Please use additional space and/or include photos if you so desire.

14558 Portal Cir, La Vista, NE 68138
402-339-2221
www.scareawaycancer.org

CONSENT FORM

Confidentiality Clause

Scare Away Cancer considers this application and its attached information confidential. Scare Away Cancer shall not use the confidential information other than for the purposes of its business with the applicant and shall disclose it only to its officers, board members, or government agencies with a specific need to know. Scare Away Cancer will not disclose, publish, or otherwise reveal any of the confidential information received from applicant to any other party whatsoever except with the specific prior written authorization of Applicant. By signing below, you give Scare Away Cancer authorization to speak with the social work department and/or doctors to verify your situation.

_____
Initial

Publicity Authorization

I authorize Scare Away Cancer to publicize information about myself or my family (including a medical condition, whether embodied in photographs, videotapes, recordings, and any other format (collectively, "Information"), for the purposes of promotion, publication, commercial advertising, or any other purpose whatsoever, now or at any time in the future. Participants understand and agree that Scare Away Cancer may use any such information: (1) in all manner and media whatsoever, whether now known or hereafter invented, including electronic and print media and the Internet; (2) with or without Participant's names; (3) without the payment of royalties or other compensation to anyone; and (4) without the need to notify them or to seek further approval before doing so.

_____
Initial

Your medical facility may be contacted to verify the treatment of noted cancer patient as well as other organizations involved with your application. Please sign this form acknowledging your approval for Scare Away Cancer to verify this information.

Patient's Signature (parent or guardian if patient a minor): _____

Date of Signature: _____

Authorizes Release of Medical Information

(Authorizes Release of Medical Information)
Description of each purpose for the use or release of the information [45 CFR 164.508 (c) (iv)]
This information will be used for the sole purpose of evaluation of the above patient for support service offered by Scare Away Cancer. This HIPAA release is valid from the date of the patient's signature shown above and only if signed by both the patient and Oncologist's Office.

Signature _____ Date_____

14558 Portal Cir, La Vista, NE 68138
402-339-2221
www.scareawaycancer.org