



August 2009

Dear Applicant:

Desert Cancer Foundation (DCF) is a nonprofit organization dedicated to assisting residents of the Coachella Valley and surrounding communities who need financial assistance in obtaining diagnosis and treatment for cancer and allied diseases.

We hope we can help you. In order to apply for assistance you must complete the attached application materials in full and provide any requested supplementary information. **If you are approved as eligible for assistance, the date of receipt of your completed application will serve as the initial eligibility date.**

Program assistance is for the payment of cancer related medical treatment. The primary consideration for acceptance in the DCF program is a demonstrated need for financial assistance to obtain local cancer treatment. Total DCF payments for your cancer treatment have a lifetime cap of \$50,000.

Please do not hesitate to contact our office at 760-773-6554 if you have any questions about our services or require assistance in completing your application.

Desert Cancer Foundation Board of Directors

Attachments: Application Checklist
Application Form
Application Criteria, Conditions & Waiver
Authorization for Release of Information
DCF Policy for Cost Capitation

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74091 Larrea Street · Palm Desert, CA 92260 · 760.773.6554 · fax 760.773.6532

www.desertcancerfoundation.org



The following items are required for consideration of your application for financial assistance is by the Desert Cancer Foundation:

- _____1. A completed and signed "Application for Financial Assistance."

- _____2. Copies of applicant's income tax returns for the last two years, plus copies of all bank statements for the past three months. If taxes were not filed for those years please provide copies of all bank statements for the last six months and a written explanation why taxes were not filed.

- _____3. Verification of income: for example, copies of paycheck or disability check stubs for the last two months, or copies of social security benefit statements, etc.

- _____4. Copies of application and/or response letters from all programs applied for such as Medi-Cal, MISP, Breast Cervical Cancer Treatment Program, etc.

- _____5. A signed release allowing Desert Cancer Foundation to discuss applicant's care with the physician/provider and social worker/ financial counselor. Please have a friend, relative, or other individual of your choosing, sign in the "Witness" section of the Release form.

- _____6. For insured clients (including Medicare), a copy of your insurance card, front and back.

- _____7. Eligibility will require written confirmation of cancer diagnosis, treatment plans and cost estimates from applicant's physician. We will request them for you following receipt of your signed medical release.

If you have any questions please don't hesitate to contact us at (760) 773-6554.

DESERT CANCER FOUNDATION
 A California Nonprofit Public Benefit Corporation
 74091 Larrea Street, Palm Desert, CA 92260
 Phone: (760) 773-6554 Fax: (760) 773-6532

Application for Financial Assistance

In order to process your application you must provide all the information requested below. Completion and submission of this application does not confirm eligibility for financial assistance.

Applicant's Name: _____
 Street Address: _____ (do not list P.O. Box unless homeless)
 City: _____ County: _____
 State: _____ Zip Code: _____
 Home Phone: _____ Work/Cell Phone: _____
 Email: _____ Diagnosis: _____
 Birth Date: _____ Social Security Number: _____ - - (required)

If there are other people living in your household, complete this section (attach more pages if needed):

	Applicant's Spouse or Significant Other	Adult/Child 1	Adult/Child 2	Adult/ Child 3
Last				
First				
Middle				
Relationship to patient:				
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth:				
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Single	<input type="checkbox"/> Single	<input type="checkbox"/> Single
	<input type="checkbox"/> Married	<input type="checkbox"/> Married	<input type="checkbox"/> Married	<input type="checkbox"/> Married
	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated	<input type="checkbox"/> Separated
	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed	<input type="checkbox"/> Widowed
Employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Employer:				
Disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Disabled:	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary	<input type="checkbox"/> Temporary
	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent	<input type="checkbox"/> Permanent

PLEASE PROVIDE INFORMATION ON ALL HOUSEHOLD INCOME AND ASSETS.

INCOME	Total \$ Amount	ASSETS	Total \$ Value
Salary	Monthly	Residence	
Pension	Monthly	Real Estate Property	
Social Security	Monthly	CDs	
Disability	Monthly	Savings	
Unemployment	Monthly	Checking	
Worker's Comp.	Monthly	Retirement accts (e.g, IRA, 401K)	
Alimony	Monthly	Automobile	
Other (Specify source)	Monthly	Other (Specify)	
TOTAL	Monthly	TOTAL	

PLEASE PROVIDE INFORMATION ON ALL MONTHLY HOUSEHOLD EXPENSES.

LIVING EXPENSES	Total \$ Cost	MEDICAL EXPENSES	Total \$ Cost
Food	Monthly	Medical Ins. Premiums	Monthly
Mortgage	Monthly	Physician's Fees	Average Monthly
Property taxes	Circle One: Annual OR Monthly	Lab Work	Average Monthly
Rent	Monthly	Prescriptions	Average Monthly
Transportation (gas, ins, paymt)	Monthly	Dental Services	Average Monthly
Utilities	Monthly		
Business Expenses	Monthly		
Other (Credit cards, etc)	Monthly	Other (Specify)	
TOTAL		TOTAL	

Are you currently employed? Yes No

If Yes, name of employer: _____

If No, what was your last date of employment? _____

Are you eligible for COBRA benefits? _____ Are you a veteran? _____

Have you applied for any of the following? (include date of application)

Medi-Cal: _____ Status of application: _____

MISP: _____ Status of application: _____

Disability:

CA State (SDI): _____ Status of application: _____

Social Security (SSI or SSDI): _____ Status of application: _____

Other Programs applied for & application status: _____

• Are you eligible for Medicare? Yes No If Yes, please answer the following questions:

Name of Medicare health plan (Senior Secure, SCAN, Secure Horizons, etc), if applicable):

Monthly premium: _____

Annual deductible: _____ Max annual out-of-pocket: _____

Do you have a Medicare Prescription Plan? Yes No

Other supplementary insurance: _____

PLEASE PROVIDE A COPY OF YOUR MEDICARE/INSURANCE CARD – FRONT AND BACK.

• If you are not eligible for Medicare, do you have private insurance? Yes No

If Yes, please answer the following questions:

Name of Insurance Carrier: _____

Monthly premium: _____

Annual deductible: _____ Max annual out-of-pocket: _____

Other supplementary insurance: _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD – FRONT AND BACK.

• Are you currently covered by Medi-Cal? Yes No

If Yes, what is your monthly Share of Cost (SOC): _____

PLEASE PROVIDE A COPY OF YOUR MEDI-CAL CARD WITH YOUR APPLICATION.

Name of Physician managing your cancer-related care: _____

Telephone number: _____

Specify financial assistance requested (REQUIRED FOR CONSIDERATION):

_____ I do not have insurance and am seeking financial assistance with the following medical costs related to my cancer diagnosis and/or treatment as recommended by my physician.

_____ Consultation

_____ Radiation

_____ Chemotherapy

_____ X-rays/Scans

_____ Laboratory

_____ Surgical procedure/Biopsy

_____ Prescriptions

Other, please specify: _____

_____ I have Medi-Cal and am seeking assistance for my monthly Share of Cost related to my cancer diagnosis and/or treatment.

_____ I have Medicare and am seeking financial assistance with co-pays related to my cancer diagnosis and/or treatment.

_____ I have insurance and am seeking financial assistance with co-pays related to my cancer diagnosis and/or treatment.

Please provide any additional information that you think is pertinent to consideration on your application for financial assistance:

I verify all of the information provided is accurate and valid.

Applicant's Signature

Date

CRITERIA FOR ELIGIBILITY

1. Applicant must be a resident of the Coachella Valley or surrounding communities, receiving cancer treatment in the Coachella Valley. Out-of-area cancer treatment may be considered when referred by a local oncologist because care is unavailable locally.
2. Applicant must have a cancer diagnosis or suspected cancer diagnosis confirmed by a physician.
3. Applicant must have a valid social security number.
4. A physician's letter stating diagnosis, treatment, and medical necessity must be received from applicant or physician's office.
5. Applicant must submit a signed release of medical records.
6. Applicant must provide documentation that demonstrates current financial need to access local cancer treatment.
7. Applicant's request for financial assistance must be limited to cancer diagnosis and treatment-related issues.

CONDITIONS OF PARTICIPATON

1. All requests for assistance are subject to Board approval.
2. All financial assistance given will be paid directly to the provider of services. Desert Cancer Foundation (DCF) policy does not permit reimbursement or payment of funds directly to clients for treatment related services.
3. Provider of service is within DCF's network of participating providers unless prior approval is obtained.
4. Scope of benefits will be determined on an individual basis following assessment of the client's needs.
5. An updated application will be required every six months (or upon request by DCF) to access continuing eligibility for benefits.

CERTIFICATION, WAIVER AND RELEASE

I certify that the above information is true and correct and that I am a patient in need of financial assistance in order to receive medical care and treatment.

By signing below, I acknowledge that the Desert Cancer Foundation, including the board of directors, honorary board members, members, officers, volunteers, employees, and/or agents (collectively, "Foundation"), has sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that the Foundation is not obligated to make or continue such discretionary financial assistance payments to me or on my behalf. I understand and hereby acknowledge that the Foundation reserves the right to refuse or terminate any and all payments for any reason at any time and without notice. The Foundation shall not be liable for any injury, disease, death or other harm, which may result following any termination or refusal to provide financial assistance. I also understand and acknowledge that any financial assistance provided by the Foundation to pay for medical treatment, care, or prescriptions is not assignable and that any assignment thereof shall be void.

By signing below, I hereby acknowledge that the Foundation is not responsible for any diagnosis, selection or appointment of physician(s) or medical treatment I require. In reviewing this application, the Foundation in no way shall be deemed to have issued a diagnosis of my medical condition or to have recommended treatment. Any evaluation of medical records is for the sole purpose of evaluating this application for financial assistance.

By signing below, I hereby release, waive, and discharge the Foundation from any and all liability, and further covenant not to sue the Foundation, as a result of any medical treatment or refusal of treatment in any way associated with this application for financial assistance or which I may receive in conjunction with any funds provided by the Foundation. I hereby acknowledge that payments by the Foundation for medical care and/or treatment, including any payments for prescriptions, will not subject the Foundation to any liability for any injuries I may receive in connection with such treatment, care or use of prescriptions. I expressly release the Foundation from any and all liability under any cause of action in connection with any injury, disease or death resulting from the medical care, treatment and/or prescriptions I may receive. In the event of a dispute, the prevailing party shall be entitled to have and recover all costs and expenses, including all attorneys' fees. I expressly agree that this Certification, Waiver and Release is intended to be as broad and inclusive as is permitted by the laws of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

I hereby certify that I have read and voluntarily signed this Application and Certification, Waiver and Release, and agree that no oral representations, statements or inducement apart from what is contained in this application have been made.

Applicant's Signature: _____ Dated: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

To Whom It May Concern:

For the purpose of continued medical care, I hereby authorize the Desert Cancer Foundation (DCF) and its representatives to discuss my Application for Financial Assistance (including but not limited to my financial information, diagnosis and treatment) and related medical care with physicians/medical providers (and their representatives) and social workers/financial counselors as needed. I also authorize the release, as needed, of any medical records and information by my medical care providers to DCF.

Patient Signature/Legal Guardian

Witness

Print Name

Print Name

Date

Date

FOR OFFICE USE ONLY

Date of Request: _____

Patient's Name: _____

DOB/SSN: _____

EFFECTIVE AS OF MARCH 15, 2005

**DESERT CANCER FOUNDATION
ADOPTED POLICY FOR COST CAPITATION
2005**

(adopted by Board of Directors on 3/15/05)

- I. Contingent upon availability of funds, Desert Cancer Foundation's Patient Assistance Policy is as follows:
 - A. Per-patient lifetime cap of \$50,000 for cancer treatment for approved treatment plan. Emergency services and/or hospitalization not part of the approved treatment plan will not be covered.
 1. A social worker/financial counselor at the facility where care is administered will assist the patient in applying for programs (i.e., MISP, BCCTP, Medi-Cal, etc.) that he/she may be eligible for at the beginning and during the course of treatment.
 2. Applicant will be required to provide DCF with a response letter from all of the above programs he/she has applied to prior to initial approval of DCF financial assistance and any subsequent approvals.
 3. A treatment plan and close cost estimate will be required from the patient's physician/provider. A letter will be sent to the physician/provider stating that the patient has applied to DCF and we are requiring a close cost estimate prior to approval.
 4. Each applicant will sign a release allowing the DCF to discuss his/her care with the physician/provider and social worker/financial counselor.
- II. All patients will be enrolled (if they qualify) in Pharmaceutical Patient Assistance Programs at the facility where care is administered.
- III. Patients will be required to reapply for financial assistance every six months.