



The Cancer Foundation of the Florida Keys, Inc.

P.O. Box 5816 ☎ Key West, FL 33045-5816 ☎ 305-294-7300 ☎

INFORMATION REGARDING APPLICATION AND RE-APPLICATION FOR ASSISTANCE FROM THE CANCER FOUNDATION OF THE FLORIDA KEYS

PLEASE READ CAREFULLY!!

The Cancer Foundation of the Florida Keys is an all-volunteer, Keys-wide, non-profit organization dedicated to assisting qualified cancer patients with living expenses while they are undergoing treatment for their disease. We do not pay medical bills. We are not connected with any other organization raising money for cancer. Most of our funds come from private donations and fund raisers. We also receive grant funds from the Florida Department of Children and Families.

INITIAL APPLICATION PACKET:

In this packet, you will find an Application for Assistance, which consists of a two-page application and a Release for Medical Information. A signed copy of this release is necessary for our files and complies with the latest Health Information Privacy Protection Act (HIPPA). Also included is a form entitled "Data Collection for Pathways" which is necessary for compliance with the specifications of the above mentioned DCF grant.

If you are in danger of being evicted from your home, we require a letter from your landlord/mortgage company addressed to you stating how much rent/mortgage payment is due, when it was due and a date when eviction proceedings will begin if the payment is not made.

If you have received notice of termination of electric and water services, please obtain a letter from those utilities stating how much is past due and a date when utility services will be terminated.

Required are:

1. **Completed Application**
2. **Signed Consent for Data Collection for Pathways**
3. **Authorization for Disclosure of Health Information**
4. **Letter from landlord/mortgage company and electric and/or water as described above, if applicable.**

Also required are:

1. Letter from your physician (s) showing diagnosis and treatment plan
2. Copy of your proof of Monroe County Residence indicated on page one of this application.
3. Copy of your lease, if any. If you do not have a lease agreement, please furnish a letter from your landlord, or copy of your coupon from your mortgage company. This may be used as proof of residency, however, Driver's License Information is preferred.
4. Copies of current utilities and/or other current living expenses.
5. **DO NOT INCLUDE MEDICAL BILLS.**

You will be notified by Regular Mail that you have either been approved or not approved for assistance. Your approval letter will include the amount of monthly assistance and the duration of that assistance. You must notify the Cancer Foundation of any changes to the information submitted with this application.

Application for Assistance from Cancer Foundation of the Florida Keys, page 2

FAX COMPLETED APPLICATION AND ALL OTHER REQUIRED DOCUMENTATION TO

305-296-0061

If you have any questions about this process, please call 305-294-7300. A representative of the Cancer Foundation will contact you.

All forms are also available for download from our website, www.keyscancer.com

Thank you and our best wishes for a complete recovery.

The Cancer Foundation of the Florida Keys.

CANCER FOUNDATION OF THE FLORIDA KEYS
APPLICATION FOR ASSISTANCE

FAX ALL PAGES OF COMPLETED APPLICATION TO 305-296-0061

Name of applicant: _____ Date of Birth: _____ M/F _____

Social Security Number: _____ Are you hearing impaired: _____

Address: _____ City _____

How long at this address? _____ Previous address, if less than 1 year: _____

Phone number where you can be reached: _____ Fax #: _____

Driver's License: State where issued: _____ License Number _____

Alternate proof of Residency: _____

Medical Insurance: Y/N _____ Terms(Co-Pay/Deductible) _____

Number of Adults in Household _____ Number of Children in Household _____

Contact information: Name,relationship: _____

Mailing address, phone number, fax number, and e-mail address if different from your own:

Reason for Assistance Request, Amount of financial help needed, and diagnosis: _____

Have you applied to other agencies for assistance, if so list: (include name and agency applied to) _____

EMERGENCY Contact information: Name/ relationship: _____

Mailing address, phone number, fax number, and e-mail address if different from your own:

INTERNAL USE ONLY

Diagnosis: _____

Date Completed Application Received: _____ Date Approved/Denied _____

Assistance Begins _____ Amount: _____ Terminates: _____

CANCER FOUNDATION OF THE FLORIDA KEYS
APPLICATION FOR ASSISTANCE
Continued

PERSONAL INCOME/EXPENSE INFORMATION:

Occupation/Source of Income: _____

*Total Monthly income for household: _____

Life Insurance: Yes No Company _____ Policy Number _____

Monthly Expenses:

Payment type	Amount	Payment type	Amount
Payment type	Amount	Payment type	Amount
Payment type	Amount	Payment type	Amount

* **Total of all sources of income**, including that of spouse/significant other, SSI, etc.

CONSENT FOR ENROLLMENT: Please Read Carefully and sign below:

I understand and agree that information supplied by me may be shared with other funding sources and community services, for benefits and planning on my behalf. I attest that I am a resident of Monroe County, and that I must pursue all relevant Federal, State, local, public and private resources for medical and financial assistance in a timely fashion before, and co-incidental with receiving any financial assistance from the Cancer Foundation of the Florida Keys. I understand that I may become ineligible for services if, at any time, I have been found to have deliberately misled any representative of the Foundation. I further understand that any help I may receive from the Foundation shall be at their discretion, and in consideration for the Foundation accepting my application and considering it. I agree to indemnify the Foundation and hold it harmless from any liability associated with their Review and decision regarding my application.

Applicant's Signature: _____ Date: _____

Applicant's Printed Name: _____

Witness: _____ Date: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I hereby authorize the Cancer Foundation of the Florida Keys to obtain from

Dr. _____

Address: _____

City/State/Zip _____

Telephone: _____

any and all information pertaining to my diagnosis of cancer and treatment of that disease. This information will be obtained upon application for financial assistance from the Cancer Foundation of the Florida Keys.

1. I understand that authorizing the disclosure of this health information is voluntary. I understand that my disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by federal confidentiality rules.
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my revocation to the Chairman of The Grants Committee.
3. I understand that if I refuse to sign, or, at any time revoke this authorization, I will become ineligible for financial assistance from the Cancer Foundation of the Florida Keys.

Date

Patient or Legal Representative Signature

Witness Signature

