FINANCIAL ASSISTANCE PROGRAM

The Willamette Valley Cancer Foundation provides financial assistance for individuals undergoing cancer treatment. Financial assistance provided by the WVCF include bills related to circumstances impacted by cancer treatment.

Qualifications:

- Must reside or receive treatment within the counties of Yamhill, Tillamook, Lincoln or the greater Grand Ronde city area
- Must have a cancer diagnosis
- Must be currently undergoing cancer treatment or within 6 months of treatment
- Must be in financial need

YOUR CHECKLIST - PLEASE PROVIDE PROOF OF THE FOLLOWING:

- ❐ *Cancer diagnosis from phycisian*
- ❐ *Insurance face sheet showing deductible & annual maximum*
- ❐ *Current bank statements of checking, savings or investment accounts*
- ❐ *Proof of income (all that apply)*
  - ❐ Recent tax return
  - ❐ Paycheck stub
  - ❐ Social Security Letter
  - ❐ Other income
- ❐ *Proof of expenses (all that apply)*
  - ❐ Utility bills
  - ❐ Rent or Mortgage statement
  - ❐ Credit card statements
  - ❐ Insurance premium statements
  - ❐ Other monthly expenses
- ❐ *Complete and sign the application & release form*
- ❐ *Return the application with all supplemental documentation to the address below*

Willamette Valley Cancer Foundation
2700 SE Stratus Avenue, Suite A
McMinnville, OR 97128
Phone: 503-435-6592 | Fax: 503-435-6591
info@wvcancerfoundation.org

Date of Application ________________________ **Case #** ___________

Applicant's Name__________________________________ Preferred Name________________________

Preferred Phone # _________________________________ Other # ______________________________

Mailing Address ____

City _______________________State______Zip __________ County ___________________________

Date of Birth ____/____/_________ Age: __________

HOUSEHOLD INFORMATION

How many people are in your household? ______, How many in the house are legal dependents?___________

1. Applicant __________________, Age _____ , Relationship to patient _________SELF_________
2. ___________________________, Age _____ , Relationship to patient ________________________
3. ___________________________, Age _____ , Relationship to patient ________________________
4 ___________________________, Age _____ , Relationship to patient ________________________
5. ___________________________, Age _____ , Relationship to patient ________________________
6. ___________________________, Age _____ , Relationship to patient ________________________

CURRENT STATUS

Are you currently employed? ❒ Yes / ❒ No, Full-time or Part-time? _______________________

Are you able to work ❒ Yes / ❒ No If No, Why? ____

What is your cancer diagnosis? __________________________________ Date of diagnosis: ____________

Oncologist_________________________________ Treatment Facility ____________________________

Type of treatment ❒ Chemotherapy ❒ Radiation ❒ Other

Are you currently receiving treatment? ❒ Yes / ❒ No If No, When was your last treatment date? ___________

First date of treatment? __________ Last date of treatment? __________ How many visits per week?_______

Have you had have surgery related to this Cancer? If yes, when? ______________________________

Primary Care Provider__________________________________ Plan of Care_______________________

INSURANCE INFORMATION

Do you have any form of medical insurance? ❒ Yes / ❒ No,

If yes, what type? ____

What is your deductible?_______________ What is your Annual Out-of-Pocket Maximum? ____________

Do you have supplemental insurance? ❒ Yes / ❒ No

If yes, what kind?____

Have you applied for disability? ❒ Yes / ❒ No, If yes, when? ____________

INCOME & ASSETS

INCOME	APPLICANT	CO-HABITANT	OTHER	OTHER
Wages				
Unemployment				
Social Security				
Retirement				
Disability				
Child Support/Alimony				
Interest/Dividends				
TANF Benefits				
SNAP Benefits				
Other				
Other				
Other				
Totals				

ACCOUNTS	APPLICANT	CO-HABITANT	OTHER	OTHER
Checking Account Balance				
Savings Account Balance				
Investments Balance				
Retirement Balance				
Other Assets				

Do you own a residence or other property? ❒ Yes / ❒ No If yes, what is the value? _______________

Do you own a 2nd residence or other property? ❒ Yes / ❒ No If yes, what is the value? _________________

Do you own any vehicles? ❒ Yes / ❒ No If yes, how many? ____________

Make _________________ Model: _________________ Year: ___________ Is there a payment? ❒ Yes / ❒ No

Make _________________ Model: _________________ Year: ___________ Is there a payment? ❒ Yes / ❒ No

Make _________________ Model: _________________ Year: ___________ Is there a payment? ❒ Yes / ❒ No

MONTHLY EXPENSES

HOUSEHOLD COSTS

Rent/Mortgage	______
Utilities	______
Groceries	______
Personal Costs	______
Other	______
TOTAL	______

AUTOMOBILE COSTS

Car Payments	______
Non-Medical Fuel Costs	______
Other	______
TOTAL	______

INSURANCE COSTS

Medical Insurance	______
Auto Insurance	______
Life Insurance	______
Other Insurance	______
TOTAL	______

ADDITIONAL COSTS

Child Care	______
Child Support	______
Alimony	______
Work/School	______
TOTAL	______

MEDICAL RELATED COSTS

	Monthly Amount	Total Amount
Co-Pays	______	
Medical Bills	______	______
Prescriptions	______	
Equipment/Supplies	______	
Home Health Care	______	
Medical Fuel Costs	______	
TOTAL	______	______

DEBT COSTS

	Monthly Amount	Total Amount
Credit Cards	______	______
Private Loans	______	______
Other	______	______
Other	______	______
TOTAL	______	______

ADDITIONAL INFORMATION?

OVERVIEW

Please mark any areas about which you are finacially concerned:

- ❐ **Rent/Mortgage**
- ❐ **Utility Bills**
- ❐ **Auto Insurance**
- ❐ **Groceries**
- ❐ **Transportation**
- ❐ **Medical Insurance**
- ❐ **Prescriptions**
- ❐ **General Living Expenses**
- ❐ **Other**

What would you like the committee to know about your situation?

____
____
____
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____

Do you give permission to another person to communicate to the WVCF on your behalf as well as provide/recieve information regarding this application? ❐ Yes / ❐ No

If yes, whom? ______________________ Phone # ______________________

If yes, whom? ______________________ Phone # ______________________

The Willamette Valley Cancer Foundation has determined that it is not required to issue a form 1099 (tax information reporting) to any grant recipient to report the award of a grant, because any payment to the grant recipient or a third party does not represent compensation for personal services. If you have any concerns or questions about the taxation of a grant from the WVCF please consult your financial advisor.

______________________________ ______________

Signature of Applicant Date

By signing this application you give WVCF permission to speak on your behalf to other non-profits and buisnesses in an effort to connect you to the most valuable resources in your area.

Authorization for Use and Disclosure of Protected Health Information

PG# ________________

Willamette Valley Cancer Foundation

2700 SE Stratus Avenue Suite A
McMinnville, OR 97128
Phone 503- 435-6592
Fax 503- 435-6591

PATIENT IDENTIFICATION:

Name: ______________________________ Date of Birth: ___/___/_____

Address: ____

____

Telephone: (____) _______________

PERSON AUTHORIZED TO RECEIVE INFORMATION:

Name: Willamette Valley Cancer Foundation

Contact: Doris Towery / Mindy Senn

Address: 2700 SE Stratus Avenue, Suite A
McMinnville, OR 97128

Telephone: 503-435-6592 Fax: 503-435-6591

DATES OF HEALTH CARE INFORMATION TO BE RELEASED:

From (date) ALL

To (date) ALL

From (date) ALL

To (date) ALL

PURPOSE OF REQUEST:

______ Treatment or consultation ______ At the request of the patient ______ Billing or claims payment

Other: Grant application for financial assistance from Willamette Valley Cancer Foundation

TYPE OF INFORMATION TO BE RELEASED: (please check all that apply)

_______ Operative Report/Consultation Reports ______ Laboratory Test Reports _______X-Ray Reports/Images

_______Housing Authority _______ History & Physical Exam _______ Medical Ins. Benefit Info

_______ Discharge Summary _______ Non-Medical Insurance Info _______ Human Resource Info

______ Copies of Utility/Household Bill statements/Itemized Bills ______ Med Third Party Resources/ Financial Counselor

Other: Verbal conversations and all medical records

Signature of Patient or Personal Representative Who May Request Disclosure

I can inspect or copy the protected health information to be used or disclosed. **I authorize Willamette Valley Cancer Foundation to use and disclose the protected health information specified above.**

Signature: ________________________________ Date: ________________________________

Office Use Only:

________Photo ID
________Matching signatures

Signature of Recipient ________________________________