505 East Perkins Avenue
Sandusky, Ohio 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Financial Assistance Checklist

Program Overview:

Funds may be used for daily-living costs such as rent, utilities, food, transportation, childcare, etc.

Eligibility Criteria:

- Currently be in treatment for cancer diagnosis.
- Reside in Erie, Huron or Ottawa county.
- Have a current annual household income at or below 300% Federal Poverty Level.
- Application submission does not assure assistance will be granted.

Instructions for Application:

1. Complete the application.
2. Your application must include copies of any of the following documents that apply to you.
3. Please attach copies, not originals, as Cancer Services cannot return any documents sent with the application.

Required documentation:

- If making wages, must provide ONE month of paystubs or a statement from employer.
- If receiving income other than wages, please provide one of the following.
    - Provide ONE month of bank statements
    - Social Security benefit letter
    - Social Security 1099
    - Copy of Social Security check
- If a patient is receiving no income, please provide a letter stating the reason for no income.
- Obtain letter from applicant's medical provider/social worker confirming current stage of cancer and applicant's current treatment plan. Letter must be on official letterhead and dated.

Applications may be emailed at CancerServicesPatients@gmail.com or dropped off at 505 E. Perkins Ave. Sandusky, OH 44870

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Financial Assistance Application

Name:			Date of Birth:
Address:			City:
State:	Zip Code:	County: ☐ Erie ☐ Huron ☐ Ottawa	
Phone:	Number of people in the household: _____		

Monthly Household Income: Please provide income for yourself and spouse. Please attach copies of your proof of income documents. (See documentations checklist).

Income and Employment Status:

Applicant's current employer**:** _____

Occupation: _____ Date of employment: _____to_____

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) _____

Spouses/Partner's current employer: _____

Occupation: _____ Date of employment: _____to_____

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) _____

Monthly Gross Income	**Self**	**Spouse**	**Total Income**
Wages/self-employment	$	$	
Social Security	$	$	
Pension or retirement income	$	$	
Unemployment	$	$	
Workers' compensation	$	$	
Other income	$	$	
Total Monthly Family Income	**$**	**$**	

Type of Cancer: _____ Stage_____

Are you receiving? _____Chemotherapy _____Radiation _____ Immunotherapy _____ Other

A current oncologist treatment plan/doctors' notes reflecting the most current diagnosis and treatment plan must be included with the application or the application will be considered incomplete.

What other agencies are you currently working with? (For example, Serving our Seniors, Job and Family Services, Care & Share, Cancer Tees Me Off, or When Pigs Fly)

Description of Need: What will the funds be used for?

Additional Comments:

☐ If you would like your application to be considered for additional support from the Madison Brenton Foundation, please check this box. Please note that while your application will be reviewed, checking this box does not guarantee funding from the Madison Brenton Foundation.

I, _____, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the Cancer Services Financial Assistance Program.

Signature_____ **Date:** _____

Relationship to applicant: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member
☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider
☐ Other (please specify): _____

Office Use Only	
Amount Approved:	Date of Approval: