



## FINANCIAL ASSISTANCE APPLICATION

*Dandelion Charity Corp.*

*To be considered for assistance, all forms must be completed and signed.  
Requests for assistance must include the HIPAA release form along with confirmation of  
diagnosis by patient's healthcare provider.*

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Patient Name

Date of Birth

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Home Address

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Email Address

Phone

Types of financial assistance offered (*check those desired*):

- Medical/Prescription Co-pays
- Grocery Assistance
- Gas & Transportation
- Utility Bills
- Rent Assistance
- Dinner Vouchers

To qualify for financial assistance from *Dandelion Charity Corp*, you must:

1. Live in Orange County, NY or be receiving cancer treatment in Orange County, NY.
2. Applicants must currently be receiving treatment for a cancer diagnosis. Qualifying treatments include chemotherapy, radiation therapy, immunotherapy, stem cell therapy, recent cancer-related surgery, as well as bone marrow or stem cell transplants. Individuals in hospice care also qualify for assistance.

Please send completed application to:

*Dandelion Charity Corp*

PO Box 126 Wallkill, NY 12589 or [info@dandelioncharity.org](mailto:info@dandelioncharity.org)

**\*Initial assistance is determined on a case-to-case basis. Any subsequent assistance is limited to funds available.**



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### MEDICAL INFORMATION

*To be completed by healthcare provider. Please complete all fields.*

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Patient Name

Date of Birth

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Cancer Diagnosis/Type

Date of Diagnosis

### TREATMENT PLAN *(check applicable)*

- Chemotherapy
- Radiation
- Surgery
- Stem Cell Transplant
- Immunotherapy
- Other *(please specify)* \_\_\_\_\_

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Name of Healthcare Provider

Title *(Physician, Nurse, Social Worker, Case Manager)*

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Address

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Email Address *(required)*

Phone

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Healthcare Provider Signature

Date

\*Please attach a HIPAA release form



**Authorization to Release Protected Health Information**

*I understand that privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), protect the use and disclosure of health information about me, also known as protected health information.*

I, \_\_\_\_\_ (*applicant name*), authorize the release of the specific information noted below to *Dandelion Charity Corp*, located at PO Box 126 Wallkill, NY 12589 in connection with my application for *Dandelion Charity Corp* financial assistance.

I authorize, \_\_\_\_\_ (*healthcare provider*), to disclose the following specific information to *Dandelion Charity Corp* at the address above covering my past, present, and future periods of healthcare:

- Cancer Diagnosis/Type
- Treatment type

This authorization will expire \_\_\_\_\_, I understand that I may revoke this authorization at any time by submitting a written request to the healthcare provider listed. I also understand that this revocation will not apply to any actions already taken in reliance on this authorization.

I understand that signing this authorization is voluntary. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that any information used or disclosed under this authorization by *Dandelion Charity Corp* may be further shared and may no longer be protected by federal or state laws.

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Print Name

Date of Birth

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Signature

Date