APPLY FOR ASSISTANCE

To apply for financial assistance please complete the application. All required forms must be filled out completely to be considered. Please note that your oncologist or social worker must confirm that you are currently receiving treatment for cancer.

QUALIFICATIONS

To qualify for the Dandelion Charity Corp Financial Assistance Program, you must:

1. Live in Orange County, NY or be receiving cancer treatment in Orange County, NY.
2. Be in active treatment for a cancer diagnosis. Active treatment includes receiving chemotherapy, radiation, immunotherapy, or stem cell therapy. This also includes recent cancer surgery and bone marrow or stem cell transplants. Patients receiving hospice care are also eligible for assistance

TYPES OF ASSISTANCE OFFERED

Whether its putting a meal on the table, getting to doctor appointments, or managing unexpected bills, we're here to help ease the burden.

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

Please send completed application to:

Dandelion Charity Corp
PO Box 126 Wallkill, NY 12589
or
info@dandelioncharity.org

Dandelion Charity Corp. Financial Assistance Application

Please complete all fields. Your application will remain confidential.

NAME **DATE OF BIRTH**

HOME ADDRESS

CITY **STATE** **ZIP CODE**

PHONE **EMAIL**

What type of assistance you would like to receive:

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

Medical Information

To be filled out by a healthcare provider

CANCER DIAGNOSIS/TYPE **STAGE**

DATE OF DIAGNOSIS

Treatment plan (check applicable):

- ☐ **CHEMOTHERAPY**
- ☐ **SURGERY**
- ☐ **RADIATION**
- ☐ **BONE MARROW TRANSPLANT**
- ☐ **STEM CELL TRANSPLANT**
- ☐ **HOSPICE CARE**

I *(patient name)* _____, give permission for *(healthcare provider's name)* _____ to share this information with Dandelion Charity Corp for the purpose of applying for a Dandelion Charity Corp Financial Assistance Grant.

PATIENT NAME *(Please print)* **DATE**

PATIENT SIGNATURE **DATE**

REPRESENTATIVE SIGNATURE

HEALTHCARE PROVIDER INFORMATION

HEALTHCARE PROVIDER NAME *(Please print)*

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

HEALTHCARE PROVIDER SIGNATURE **DATE**

PHONE NUMBER **EMAIL ADDRESS** *(Required)*

**Please attach a HIPAA release form, completed by the healthcare provider listed above.*

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. By my signature on this form, I 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.

1. I authorize to disclose the following specific information to Dandelion Charity Corp at the address above covering my past, present, and future periods of healthcare:

A. *Cancer Diagnosis / Type*
B. *Stage (I, II, III, IV, or unknown)*
C. *Treatment: Scheduled or To Be Scheduled*
D. *Type: Chemotherapy, Surgery, Radiation, Transplant, Hospice*

2. This authorization will expire _____ . I understand that I have the right to revoke this authorization at any time by writing to the healthcare provider noted. I understand that I may revoke this authorization except to the extent that action has already been taken based on the authorization.

3. 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.

4. I understand that information used or disclosed pursuant to this authorization may be disclosed by Dandelion Charity Corp and may no longer be protected by federal or state law.

SIGNATURE **DATE**

PRINT NAME

PRINT ADDRESS