**Chenango Health Network (CHN)**
**Financial Assistance Program Application**
**Breast Cancer patients**

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ New York Zip: _____

Home Phone number: _____ Cell Phone Number: _____

Email Address: _____

Are you currently being treated? ___ No (if no-not eligible for assistance) ___ Yes, if so what treatments: _____

_____

**Medical Provider Attestation that Applicant is a Breast Cancer Patient**

_____ _____
Date of Breast Cancer Diagnosis Stage of Cancer

_____ _____ _____
Print Provider Name Provider Signature Date

_____
Hospital/Medical Center Name & Address

**Assistance Requested** (check all that apply**)** ___Gas Cards ___Medical Bills ___Prescriptions ___Medial Supplies ___Other

Please describe your need: _____

_____

Amount of Financial request: $_____

I give permission to Chenango Health Network to speak with this friend/family member about my request:

Name: _____ Phone: _____

**General Information:** ___ yes - I have medical Insurance (Please complete below) ___ No - I do not have medical Insurance

Insurance Provider(s): _____ Group/Policy Number:_____

Annual Deductible amount: $_____ Annual Household income: $_____ # in household: _____

(Attach all proof of income documentation – see page 2 for list of acceptable documents)

Are you currently working: ____ FT ____ PT Employer: _____

Have you lost time from work due to your cancer diagnosis? _____

Have you received assistance from the St Agatha Foundation in the past? ____No ____Yes

If Yes, When? _____ How much? $_____

*CHN does not release personal information to anyone except to gain assistance in providing you with the help you seek. Please sign this form, indicating that CHN has your permission to share or obtain personal, confidential information to organizations and/or individuals who may assist in providing that help or may require accounting or monitoring information.*

Applicant Signature: _____ Date: _____

You must be a resident of Chenango County to be eligible for the Financial Assistance Program. Please provide a copy of the invoices or bills to be paid. Please note that all expenses are paid directly to the provider vendor, and we cannot reimburse the patient for any bills already paid. *Only one application may be submitted within six (6) months. You may reapply for assistance if you have a recurrence/special circumstances.*

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Please note that the Financial Assistance Program priorities are as follows in order of importance

- Medical bills not paid by insurance
- Co-pays
- Prescription drugs (related to cancer diagnosis)
- Medical supplies
- Gas and transportation for medical appointments

Chenango Health Network cannot pay for:

- Living expenses – rent, utilities, cable bills, groceries, water bills, etc.
- Auto insurance or auto repair bills
- Tax bills of any kind

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List of Acceptable Proof of Income Documentation:

- Copy of most recent Federal Income Tax filing (pages 1 & 2)
- Copy of Unemployment Insurance benefit letter
- Copy of Disability or Workers Compensation benefit letter
- Copy of Medicaid and/or Social Services benefits statement
- Copy of Social Security benefits statement
- Copy of Retirement fund and/or Annuity statement

*Important: if you do not file Federal Income taxes, please note on the front of this application

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If you need assistance with this application, please contact our office at 607-337-4171. Please return your completed application with proof of income documentation to:

Chenango Health network
24 Conkey Avenue
Norwich, NY 13815

**This program is funded through the St. Agatha Foundation - assistance is dependent upon availability of funding.**