CASTING FOR HOPE

Attending to the financial, emotional, and spiritual needs of women living with ovarian and gynecological cancers in western North Carolina.

OVARIAN AND GYNECOLOGIC CANCER SURVIVORS

A gynecological cancer survivor who is experiencing budgetary hardship brought on by treatment costs, is concerned about her own and her families' well-being, and is seeking direction through the cancer care maze, may benefit in a number of ways by contacting *Casting for Hope*. A CFH director will use applicable resources to aid in easing the minds of hopeful women who have heard, "You have cancer."

To ask about available resources and to request an assessment and application, contact executive director, Kathy Haney, at (828) 712-2716 or Kathy@castingforhope.org.

Assistance Eligibility:

An applicant must—

- Have a diagnosis of a gynecological cancer (cervical, endometrial, ovarian, uterine, vaginal, or vulva/vulvar)
- Live in one of the 18 western North Carolina counties
- Be in financial difficulty

If eligible, complete and submit these documents:

- *Casting for Hope* Application
- Information Release Statement
- Proof of Income (Copy of recently filed taxes and current or most recent pay stub or bank statement)
- Pathology Report, Progress Notes, and if required, Letter of Medical Necessity
- Copy of statement or invoice from service provider(s), if applicable

Mail application to:

Casting for Hope
P. O. Box 8118
Asheville, NC 28814

An applicant may receive unofficial approval for assistance after a telephone or in-person assessment and be granted official approval after receipt of application and all required documents. The extent of assistance is based on neediness, access to other sources, and available means. An application will be updated as required, and/or renewed annually if eligibility requirements are met.

Financial assistance is awarded at the discretion of *Casting for Hope* directors and is determined by the availability of funds. Pay outs are made directly to service providers (i.e. pharmacy, lab, hospital, physician).

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Assistance Application

Print legibly and complete all information.

Patient Information

First Name: ______________________________ MI _______ Last Name: _________________________________

Social Security #: __________________________ Birth date: ___________ Ethnicity: ________________________

Street Address: ____

City: _________________________________ County: _______________ State: _______ Zip: ______________

Mailing Address (if different): ____

Phone number(s): ____________________ ____________________ E-mail: ______________________________

Type of cancer: _________________________ Physician/Oncologist: ___________________________________

Date of diagnosis: ______________________ Current treatment: _______________________________________

Insurance Information

Insurance Company: ________________________________ ID Number: _________________________________

Do you have a prescription drug plan? Yes No Type of plan: ____________________________________

Do you receive state assistance? Yes No Do you receive assistance from other sources? Yes No

If yes, please list: ____

Financial and Household Information

Total Monthly Net Family Income: $__________________ Total number in household: ______________

Number of Adults: _______________

Total Family Liquid Assets: $__________________ Number of Children: ______________

Ages of Children: ______________

Out-of-Pocket Medical Expenses: $_______________ monthly Current Employment Status: _____________

Assistance is being requested for (be specific): ____

____

Who referred you to Casting for Hope? __________________________________ Phone #: __________________

I attest to the above information being correct and complete to the best of my knowledge.

____ ________________________

Applicant Signature **Date**

Please include required documents (see cover letter) and any applicable information with this form.

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Information Release Statement

By my signature, I authorize the release of the information provided on my application to *Casting for Hope* and I authorize *Casting for Hope* to use same information to contact my insurer, other potential funding sources, social workers, or patient advocacy organizations on my behalf to determine my eligibility for alternative financial and other support through *Casting for Hope*.

I also authorize *Casting for Hope* to contact my insurer, health care provider, or dispensing agent, and I authorize aforementioned entities to disclose information to *Casting for Hope*, relative to my medical condition, treatment or drug therapy as requested. Disclosure of this information may include, but is not limited to, the electronic transmission of information. *Casting for Hope* agrees to request only that information needed to process my application, to renew it, and to provide continued assistance during my time of eligibility. *Casting for Hope* agrees not to disclose any information obtained from these sources to any third party except as authorized by me or as required by applicable law.

This authorization shall continue in effect until final decisions have been made regarding my application. I understand that submitting this application does not guarantee financial or any other support from *Casting for Hope.*

Applicant's Name: ____ **Date:** __________________
Printed Name

____
Signature

I grant *Casting for Hope* **permission to discuss my application with the following:**

1.____________________________________ ________________________________
Name **Relationship**

2.____________________________________ ________________________________
Name **Relationship**

I authorize the release of the following:

Pathology Report(s) Most Recent Progress Notes Letter of Medical Necessity (if applicable)

TO: *Casting for Hope*
P. O. Box 8118
Asheville, NC 28814

FROM:
____
____
____

____ ______________________
Printed Patient Name Date of Birth

____ ______________________
Patient Signature Date Signed