CASTING FOR HOPE

OVARIAN AND GYNECOLOGIC CANCER SURVIVORS

A gynecological cancer patient 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."

Casting for Hope may provide assistance to a woman at any phase of a gynecological cancer—from pre-treatment, through treatment, at post-treatment, and even to self-care.

To inquire 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, or have had, a gynecological cancer diagnosis (cervical, endometrial, ovarian, uterine, vaginal, or vulva/vulvar)
- Live in or receive treatment in North Carolina
- Be in financial difficulty

If eligible, complete and submit these documents (Check documents submitting. Submit page with application.):

- ☐ *Casting for Hope* Application
- ☐ Information Release Statement and Permission to Discuss page
- ☐ Personal Health Information (PHI) Release form
- ☐ Proof of Income (Copy of recently filed taxes, or current or most recent pay stub, or bank statement, or Social Security letter)
- ☐ Pathology Report, Progress Notes, and if required, Letter of Medical Necessity
- ☐ Copy of statement(s) or invoice(s) from service providers, 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 renewed annually (if eligibility requirements continue to be met).

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

Call 828-712-2716 or email Kathy@castingforhope.org to share your story and review options.

~ Submit the original of this checklist with the application. Keep a copy of this page for your records ~

CASTING FOR HOPE

2020 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: _____ Date of recurrence (if applicable): _____

Current treatment and treatment plan: _____

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 in Household:
(ages 18 and under) _____

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's Signature **Date**

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

Revised 2020

CASTING FOR HOPE

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: _____
Printed Name

_____ **Date:** _____/_____/_____
Signature

Permission to Discuss

I grant *Casting for Hope* **permission to discuss my application with the following person(s) or entities:**

1. Name: _____ Relationship: _____

   Address: _____

   Phone number(s): home _____ cell _____ work _____

2. Name: _____ Relationship: _____

   Address: _____

   Phone number(s): home _____ cell _____ work _____

3. Name: _____ Relationship: _____

   Address: _____

   Phone number(s): home _____ cell _____ work _____

Applicant's Name: _____
Printed Name

_____ **Date:** _____/_____/_____
Signature

- NOTE: This page requires a signature in two (2) places.

CASTING FOR HOPE

Casting for Hope is a nonprofit that assists gynecological cancer patients in various ways. Through our assistance program we may offer assistance with transportation to medical appointments, prescription and over-the-counter medications, medical bills, and personal requirements, among other things.

In order to qualify, an applicant must complete a *Casting for Hope* application and information release form(s), have confirmation of a gynecological cancer diagnosis (and recurrence when applicable), have an indicated treatment plan, and provide other information as listed on the application cover letter and as requested.

The patient identified below has granted *Casting for Hope* **permission to request personal health information** (PHI) so that we may aid in the application and qualification process.

Patient's Name:_____ **Date of Birth**:_____/_____/_____
Address:_____ Phone:_____

My signature below indicates that I understand the purpose for this release and for the request for information in order to qualify for assistance through *Casting for Hope*. I understand that:

- This authorization for the release of my health information is voluntary.
- As applicable, this release may include information related to my health beyond cancer diagnosis and treatment unless limited by the selections marked below.
- In writing, I may revoke this authorization at any time. Revoking will not affect any disclosures made prior to revocation. Unless revoked, or an expiration date is noted here_____, this authorization will expire in one year. (*Casting for Hope* reserves the right to request updated health information periodically within this year.)
- Casting for Hope will not use or share my health information without my permission, except to qualify me for assistance and as allowed or required by law.
- I may ask for and get a copy of this authorization. A readable photocopy or facsimile of this document shall have the same force and effect as the original.

Disclose the requested information from my medical records as listed here:
☐ Pathology report ☐ Office visits ☐ Provider notes ☐ Lab results ☐ Billing information
☐ Letter of medical necessity (if applicable) ☐ Other (specified as) _____

Date(s) of service: _____ Date range(s):_____

Requested Format: ☐ Electronic media ☐ Paper ☐ Other: _____
Delivery Method: ☐US Mail ☐ Pick-up ☐ Fax: _____ ☐ Other:_____

I hereby authorize disclosure of my personal health information (PHI)/medical records to:
Casting for Hope, P. O. Box 8118, Asheville, NC 28814 Phone: 828-712-2716 Fax: 828-683-3416

_____
Patient's printed name

_____ _____/_____/_____
Patient's Signature **Date signed**

For a representative acting on behalf of this patient, indicate relationship to patient:
☐ Relative—Specify:_____ Name and contact information:
_____ (Proof of relationship may be required)
☐ Power of Attorney ☐ Patient Navigator/Advocate ☐ Other_____
Name and contact information: _____ (Proof of relationship may be required)