Diagnosis: _____

Doctor: _____

APPLICATION FOR ASSISTANCE

Name of Cancer Patient: _____ **DOB:** _____

Address: _____**City:**_____ **State:**____ **Zip:**_____

Phone: _____ **Email** _____

Occupation: _____ **Employment Status:**_____

Spouse, Parent or Contact Person: _____**Phone:**_____

Occupation: _____ **Employment Status:**_____

Number of Individuals Living in Household: _____ **Ages:** _____

Health Insurance: Medicare _____ Medicaid _____ Private Ins_____ Self-Pay _____

ALL Monthly Household Income (after taxes): *List all individuals currently contributing to your household income.*

Salaries: $_____ $_____ $_____
Social Security: $_____ $_____
Social Security Disability, Work Comp $_____
Pension/Retirement $_____
Other Income: $_____
Child Support: $_____

Total All Household Monthly Income: $_____

Is A Change In Income Anticipated? Yes____ No_____ If Yes, how much? _____

Medicaid or DHHS Assistance? Yes: _____ No: ____ Applying _____
If Yes, list what you are receiving: Food Stamps: $_____ ADC: $_____ WIC: _____
Housing: _____ Other: _____

Monthly Expenses: (Please Indicate Dollar Amounts)

Rent/Mortgage	_____	Medication	_____	**Insurance**	
Utilities	_____	Groceries/Household	_____	Health	_____
Phone	_____	Monthly CC Payments	_____	House	_____
Television	_____	Total Monthly Loan Payments	_____	Car	_____
Gasoline	_____	List Loans	_____	Life	_____
			_____	Other	_____

Annual Out of Pocket Medical Obligation _____

Other Expenses: _____

**If needed please make notes or attach more information to clarify expenses/income*

(OVER)

PLEASE CHECK TYPES OF ASSISTANCE REQUESTING:

Mileage/Gasoline	_____	Lodging-Local	_____	Car Payment	_____
Groceries	_____	Lodging-Out of area	_____	Car Repair	_____
Mortgage/Rent	_____	Meals (if staying local)	_____	*Pharmacy-limited*	_____
Utilities	_____	Transportation	_____	*Insurance-limited*	_____

I, the undersigned, attest that I have a cancer diagnosis. I acknowledge that my diagnosis and treatment status will be verified with medical providers prior to assistance being offered. I authorize the Festival of Hope's designated Liaison to secure my medical record information regarding my diagnosis and treatment status to verify eligibility for all reimbursement requests.

I understand the management of Festival of Hope funds is through the Oregon Trail Community Foundation and the Festival of Hope Board of Directors. I understand all information is confidential and will be used only to determine eligibility for assistance and provide reimbursements.

I understand it is my responsibility to provide original bills, receipts and fully completed mileage forms prior to payment being rendered. Proof of monthly expenses and income of all persons living in the household may be requested. It is my responsibility to notify Festival of Hope of any changes of treatment status, income, or other factors that affect benefits.

Festival of Hope may communicate directly with my landlord when rent assistance is requested. Festival of Hope may communicate directly with the Financial Assistance Department at Regional West Medical Center if assistance is requested.

Following approval of this application I will meet with the Festival of Hope Liaison to discuss the extent of assistance Festival of Hope will provide.

Signature of Applicant or Guardian: _____

Relationship to Applicant (if Guardian): _____ **Date:** _____

Witness (if not patient's signature): _____

Send completed Application to: **Festival of Hope - Cancer Treatment Center**
Attn: Jennifer Hiltgen
3911 Avenue B Suite G100
Scottsbluff, NE 69361 **308-630-1535**

Or Email to: **Jennifer.Hiltgen@rwhs.org**

DO NOT WRITE BELOW THIS LINE

Diagnosis & Physician Verified: _____
Other information/Notes: _____
_____

Approved: _____ Denied: _____ Reason for Denial: _____

Signature of Festival of Hope Liaison: _____

Updated 5/2023