1 cancer source Assistance Program

Cancer1Source Assistance Program
50 Whittemore St., Gloucester, MA 01930
Phone: 844-361-2406 Fax: 888-246-6527

GENERAL INFORMATION

Eligibility for all Cancer1Source programs

(Must meet all criteria)

1. You are a Massachusetts resident
2. You have a cancer diagnosis
3. You have a household income less than 400% of the federal poverty level

> ***Cancer1Source provides financial assistance of up to $150.00/per person/per year. You may apply for more than one program; however, the maximum assistance per person is $150.00/per person/per year.***

Programs provide support for:

- Cancer Genetic and Genomic Testing (including Genetic Counseling)
- Medication Assistance
- Transportation Assistance
- Meals and Food Assistance
- Lymphedema Garment Assistance
- Wig/Hairpiece Assistance

Please be sure to answer ALL questions completely, sign and submit all required documentation.

Send your application to ***Cancer1Source Assistance Program, 50 Whittemore St., Gloucester, MA 01930*** or ***fax to 888-246-6527***.

Incomplete or unreadable applications will be returned. You must re-submit your application within 2 weeks to be considered for program assistance. If you re-submit your application longer than 2 weeks from rejection, your application will not be eligible for consideration.

PROGRAMS I AM APPLYING FOR

- ☐ Cancer Genetic/Genomic Testing
- ☐ Medication Assistance
- ☐ Transportation Assistance
- ☐ Meals and Food Assistance
- ☐ Lymphedema Garment Assistance
- ☐ Wigs/Hairpiece Assistance

cancer 1 source **Assistance Program**

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PATIENT INFORMATION (All required)

First Name:_____ MI: _____ Last Name:_____

Gender: ☐ M ☐ F ☐ LGBTQ

Street Address: _____

City:_____ State:_____ ZIP Code:_____

Phone Number: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Email: _____
By providing your email you are giving Cancer1Source permission to contact you this way.

Fax: _____
By providing your FAX you are giving Cancer1Source permission to contact you this way.

HEALTH INSURANCE

I have health insurance: Yes _____ No _____

Insurance Limitation (Check one): Co-pay too high _____ No Insurance _____ Other _____

MEDICAL INFORMATION

I have been diagnosed with cancer: Yes _____ No _____

Gender: Female_____ Male _____ Other_____

Proof of diagnosis is required.
One sentence stating the diagnosis is sufficient
___Letter from physician on office stationery
___Note on prescription pad
___Other

INCOME INFORMATION

Income Maximum for 400% of Federal Poverty Level

Household Size	Where You Live		
	48 Contiguous States and D.C.	Alaska	Hawaii
1	$58,320	$72,840	$67,080
2	$78,880	$98,560	$90,720
3	$99,440	$124,280	$114,360
4	$120,000	$150,000	$138,000
5	$140,560	$175,720	$161,640
6	$161,120	$201,440	$185,280
7	$181,680	$227,160	$208,920
8	$202,240	$252,880	$232,560

For each additional person in your household, add the following:
48 contiguous states - $20,560 Alaska - $25,720 Hawaii - $23,640

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HIPAA INFORMATION

I, _____ , agree that the information and documents provided in connection with this application are complete and accurate. I agree that I have documentation to support the information submitted in the application if requested.

I agree to immediately inform the Cancer Resource Foundation if my income or insurance status changes during the course of my participation in this Program. I understand that my information will be used by the Program sponsor, Cancer Resource Foundation, for purposes of determining my participation in, and administering the Program, which may include contacting me as well as my Doctor/Healthcare Provider, office/hospital staff, insurer (public/provider) or others. I understand a representative from the Program, may contact me for additional information. I authorize and consent to release identifiable information about me including medical, financial and insurance records and information as required for participation in the program. My authorization includes release of information related to my medical conditions and treatment, if required. I understand that identifiable information about me will be kept confidential and will not be further used or disclosed except to administer the Program, or as required by law. I understand that information I authorize to be disclosed may be re-disclosed and is no longer protected by Federal privacy regulations. I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization however this authorization is required for eligibility in this grant assistance program. This consent shall be in effect until revoked by the patient.

Sign Here _____ _____ _____
Patient Signature | Print Name | Date

Signature and date of another person we can disclose info to.

Sign Here _____ _____ _____
Signature | Print Name | Date