Welcome to the Bettie Jane Cancer Foundation Application Process

Attached is the application for financial assistance, you must meet some guidelines including:

1. Any cancer patient in active treatment, who is a resident of Frederick, Washington or Allegany counties or a patient receiving treatment in Frederick county.
2. You must complete the application legibly in entirety, including the section completed by the physician.
3. Patients must provide documentation of need (including income and billing statements) to substantiate financial hardship due to their cancer diagnosis.
4. The BJCF Board will meet to determine the amount of assistance to be paid for each eligible candidate based on the information provided. There is a yearly limit of $5,000/applicant. It is to the discretion of the board to make exceptions when there is a significant financial need.
5. At the time of application, you must submit current bills (that are unpaid) with all the information included for the foundation to make appropriate payments. An incomplete or a copy of only the payment stub will delay the payment process. We need a clear account number, contact numbers and any significant information included with your request.
6. Examples of services or medical expenses we will assist financially **(we cannot reimburse already paid bills or pay credit card accounts)**
    a. Co-pays for medical services or hospital services
    b. Gas cards for transportation to treatments
    c. Utilities
    d. Food allowances – grocery cards $100/per household family member
    e. Cosmetic accessories (wigs, mastectomy bras or prosthesis)

Patients who meet these requirements will be eligible to receive assistance regardless of race, sex, religion and any other potentially discriminating factor.

Our goal is to help you through your Cancer journey financially, so you can devote your energy to healing.

Please feel free to contact us with any questions,
The Bettie Jane Cancer Foundation

_____
Patient Acknowledgement

Bettie Jane Cancer Foundation

PO Box 225 Braddock Heights, MD 21714

Serving Frederick, Washington and Allegany Counties

Patient Section

(Note: This section to be completed by the patient/person requesting financial assistance)

Application Date: _____

Full Name: _____

Date of Birth: _____Age: _____

Address: _____

Phone Number: _____

Disabled? Yes / No Gender: Male / Female

If patient is a minor, name of parent guardian: _____

Marital Status: Single / Married / Divorced

Employer: _____ Phone: _____

Address: _____

Spouse Full Name: _____

Spouse Employer: _____ Phone: _____

Spouse Employer Address: _____

Members in the Household including applicant Adults #_____ Children (Ages 0 – 18) #_____

Salary		Social Security Income	
Pensions		Short Term Disability	
Unemployment		Public Assistance	
SS Disability		Other Income	

(Note: While no specific income guidelines are set, the foundation reserves the right to award to those in the greatest of need financially. Please attach documentation to support financial hardship)

Are you receiving assistance / have applied to any other organizations for help?

If so, who? _____ Were you Approved or Denied?

Health Insurance Information:

Does the patient have health insurance?

If yes, please provide the following information:

Name of Provider: _____

Address: _____

Insurance Policy Number: _____

Deductible Amount: _____

Co-Payment Amount: _____

Prescription Coverage: _____

Doctor's Office and Pharmacy Information

Doctor/Office Name: _____ Phone:

Address: _____

Name of Nurse or Patient Advocate at office: _____

Financial Needs (Please refer to #6 on Page 1)

Insurance Premiums	
Pharmacy Drug Costs	
Other (Please explain)	

This Information provided is truthful and accurate to the best of my knowledge

Falsification can lead to prosecution

Signature of Applicant Date

Medical Information

Note: This section to be completed by your Oncology Doctor, Nurse, Social Worker, or Hospital ACS Patient Navigator Only)

Doctor's Name: _____

Doctor's Address: _____

Doctor's Phone: _____ Doctors Fax_ _____

Date of Patient's Diagnosis: _____

Primary Cancer: _____

Current Stage: _____

New or Recurrence (please circle)

Is the Patient undergoing active treatment? If no indicate the frequency of follow up (yearly, every 6 months, other) _____

Type of treatments received in the past 12 months. (Circle all that apply)

Chemotherapy / Radiation / Surgery / Hormonal / Bone Marrow / Stem Cell Treatment / Palliative Care

Name and Title of Person Completing this Section: _____

Signature of Person Completing this Section: _____

For Internal Use Only

Application #: _____

Date Approved / Denied _____

Application Check List:

☐ Patient Acknowledgement

☐ 3 Page Application Completed

☐ Taxes from previous years

☐ Proof of Income (one of the following)

(A) Paystub_____
(B) W-2 _____
(C) Letter of Employee _____

Copies of all bills requesting for payment need to be attached with the application as describe in # 6 on Page 1 for prompt payment

Future request will require the current statement or bill when requesting payment