CANCER SERVICES
Resources. Support. Education.

505 E Perkins Avenue
Sandusky, OH 44870
www.CancerResources.org

Phone: (419) 626-4548
Fax: (419) 502-0222
CancerServicesPatients@gmail.com

Financial Assistance Checklist

Program Overview: Cancer Services offers financial assistance to help with essential daily living expenses such as rent, utilities, childcare, car repairs, and more. If your funding need is not listed above, please include a brief explanation on the application detailing how the funds will be used.

Eligible individuals may receive up to **$200** in financial assistance within a rolling 12-month period.

Eligibility Criteria:

- Currently undergoing active treatment for cancer diagnosis.
- Reside in Erie, Huron or Ottawa county.
- Have a current annual household income at or below 300% Federal Poverty Level.
- Application submission does not assure assistance will be granted.

Instructions for Application:

1. Complete the application.
2. Your application must include copies of any of the following documents listed below that apply to you.
3. Attach copies (not originals) of the required documentation listed below, as Cancer Services cannot return submitted documents.

Required Documentation:

☐ **Proof of Income** (if applicable):

- If employed, provide **ONE month of paystubs** or a statement from your employer.
- If receiving income from other sources, submit one of the following:
  - ONE month of bank statements
  - Social Security benefit letter
  - Social Security 1099 form
  - Other forms that apply to source of income.
- If the applicant has no income, a written explanation must be provided.

☐ **Medical Verification:**

- A letter from the applicant's medical provider or social worker confirming the current stage of cancer and treatment plan.
- The letter must be on official letterhead, date, and signed by medical professional.

☐ **Expense Documentation:**

- Attach a copy of the bill, receipt, or quote related to the funding request provided on the financial assistance application.

Processing Time & Additional Resources:

- Processing applications may take up to **30 days** for approval and reimbursement.
- If there is an **urgent need**, please dial **211** for connection to additional resources.

Applications may be emailed to: CancerServicesPatients@gmail.com
or mailed/dropped off at Cancer Services (505 East Perkins Avenue Sandusky OH 44870)

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Financial Assistance Application

Name:			Date of Birth:
Address:			City:
State:	Zip Code:	County: ☐ Erie ☐ Huron ☐ Ottawa	
Phone:	Number of people in the household:		

Monthly Household Income: Please provide income for yourself and spouse/partner. Please attach copies of your proof of income documents. (See documentations checklist).

Income and Employment Status:

Applicant's current employer**:** _____

Occupation: _____ Date of employment: _____to_____

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) _____

Spouse's/Partner's current employer: _____

Occupation: _____ Date of employment: _____to_____

Status: ☐ Full-time ☐ Part-time ☐ FMLA ☐ Unemployed ☐ Retired ☐ Disability

Other: (please explain) _____

Monthly Gross Income	**Self**	**Spouse**	**Total Income**
Wages/self-employment	$	$	
Social Security	$	$	
Pension or retirement income	$	$	
Unemployment	$	$	
Workers' compensation	$	$	
Other income	$	$	
Total Monthly Family Income	**$**	**$**	

Type of Cancer: _____ Stage_____

Are you receiving? _____Chemotherapy _____Radiation _____ Immunotherapy _____ Other

What other agencies are you currently working with? (For example, Serving our Seniors, Job and Family Services, Care & Share, Cancer Tees Me Off, or When Pigs Fly)

Description of Need: What will the funds be used for? (Please attach a copy of the bill or receipt related to the funding request)

Additional Comments:

☐ If you would like your application to be considered for additional support from the Madison Brenton Foundation (MBF), please check this box. Please note that while your application will be reviewed, checking this box does not guarantee funding from the MBF. It may take up to a month to hear from the MBF.

I, _____, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the Cancer Services Financial Assistance Program.

Signature_____ **Date:** _____

Relationship to applicant: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member
☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider
☐ Other (please specify): _____

Office Use Only	
Amount Approved:	Date of Approval:

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Call us at 419-626-4548 for any questions