Application for Transportation Assistance Fund

Email or fax completed application to:
pfs@theNCCS.org
(314) 735-2014 (fax)

Transportation Assistance Fund

- Transportation for a child and caregiver to get to and from treatment.
- Lodging when a child is away from home for treatment and other non-profit lodging is not available.

Eligibility Checklist:

- ☐ Your child must be diagnosed with cancer. If your child has a brain tumor, the tumor must be high grade (III or IV) or anaplastic to be eligible.
- ☐ Your child must have been diagnosed on or before his/her 18th birthday and treated before his/her 21st birthday. Adults who relapse after their 18th birthday and who were not previously assisted are not eligible for services.
- ☐ Your child must be a citizen of the United States or reside in the United States with an I-551 card (green card) for 12 months without prior history of the current illness.
- ☐ You must have less than $5,000 in easily accessible bank accounts (such as checking, savings and fundraising accounts).

To receive financial assistance from the Transportation Fund, please complete pages 2, 3 and 4 of the application.

Emergency Assistance Fund

- $300 in emergency assistance per year to help families offset expenses. Assistance may be used for mortgage, rent, utility payments, child care, health insurance premiums, car expenses, or treatment related expenses (such as meals away from home, prescriptions, parking).

Eligibility Checklist:

- ☐ You must meet all eligibility guidelines for the Transportation Assistance Fund listed above.
- ☐ Your child must have been inpatient or relocated for treatment for 15 consecutive days. This stay must have occurred within the past 90 days in order to qualify for emergency assistance.
- ☐ A letter indicating the dates of your child's stay from your child's hospital social worker will be needed.

To receive financial assistance from the Emergency Fund, please complete pages 2, 3, 4 and 5 of the application, if it is the first time you are coming to the NCCS for any assistance.

Anti-Discrimination Policy:
You and your child will not be discriminated against or denied assistance because of your race, religion, color, national origin, gender or political affiliation. All financial applications will be reviewed on a case-by-case basis and final determination will be made based upon your eligibility, NCCS guidelines and the availability of funds.

OFFICE USE ONLY
Date Recv'd_____

Please PRINT in black or dark blue ink and complete ALL sections accurately

Child/Patient Information – Must be completed

Patient Name (first, middle, last) _____ ☐ Male ☐ Female

Ethnicity: ☐ African American ☐ Asian ☐ White ☐ Hispanic/Latino ☐ Opt-Out ☐ Other (explain) _____

Date of Birth _____ Birthplace (state/country) _____

Patient's Address_____

City/State/Zip_____ County_____

What best describes the type of community you live in? ☐ Urban ☐ Suburban ☐ Rural ☐ Native/Tribal Land

Is patient applying for assistance independent from guardian(s)? ☐ Yes ☐ No

Please consider sending a photograph of your child with the application or by email to pfs@theNCCS.org with name and date of birth.

Parent/Guardian Information – Must be completed

If guardians do not reside in the same household and both are seeking financial assistance, both guardians must fill out separate applications.

Parent/Guardian Name(s) _____

Primary Phone # (_____) _____ ☐ Landline ☐ Cell

Secondary Phone # (_____) _____ ☐ Landline ☐ Cell

Can NCCS email updates to you regarding upcoming events and happenings? ☐ Yes ☐ No

Email _____

Is address same as patient? ☐ Yes ☐ No If no, address_____

City/State/Zip _____

Marital status of Parents/Guardians ☐ Single ☐ Married ☐ Divorced ☐ Cohabitants ☐ Widowed ☐ Separated ☐ Other_____

If divorced, who is the custodial guardian of the patient/child? _____

Do guardians speak English? ☐ Yes ☐ No If no, primary language? _____

Medical Information – Must be completed

A letter from child's hospital social worker or other hospital professional explaining the child's diagnosis, family situation, treatment plan for the next 60 days and the assistance being requested is needed in addition to completing this section. Health providers are reminded that they must comply with the HIPAA requirements when presenting NCCS with patient information.

Referring Hospital _____

Social Worker (first and last name) _____ Phone # (_____) _____

Email _____

Mailing Address _____ Dept. _____

City/State/Zip _____

Diagnosis _____ If brain tumor, grade of tumor*_____

Date of diagnosis (m/d/yyyy) _____ # of relapses_____

Date(s) of relapse (m/d/yyyy) _____

*A doctor's letter documenting the child's diagnosis and grade is required for children diagnosed with a glioma, ependymona or astrocytoma. The NCCS reserves the right to request a doctor's letter when deemed necessary.

Household Income

Total annual family income $_____

Family income sources (please check all that apply):

☐ Salary ☐ SSI ☐ Child Support ☐ TANF ☐ Other

Guardian's Employer_____
Is Parent/Guardian on unpaid leave? ☐ Yes ☐ No

Guardian's Employer_____
Is Parent/Guardian on unpaid leave? ☐ Yes ☐ No

Banking

☐ Check here if family does not have a bank account

Please list your checking/savings and other easily accessible accounts in the space provided. **Include any fundraising accounts that have been established on behalf of your child.** ***Copies of your most recent statements for all of the accounts below must be included***. *Remember, you must have less than $5,000 in easily accessible accounts to be eligible for assistance.*

Bank Name	Account Type	Account Number (last 4 digits)
Ex.: Bank of America	*checking*	4321

☐ Check here if family has a fundraising account (**If checked, please provide a copy of the balance.**)

Insurance Information

Does patient have health insurance? ☐ Yes ☐ No

If yes, please indicate what type of insurance (check all that apply):

☐ Private ☐ Medicaid ☐ Medicare ☐ Other

Does insurance provide assistance with transportation or lodging expenses? ☐ Yes ☐ No

Funding Procedures

1. A case manager will contact you by phone once the application has been received and processed by the NCCS to determine how we can best assist you.
2. Transportation assistance may be provided for up to 60 days. Financial assistance is not retroactive. In order to request additional transportation assistance, you must have a hospital professional submit a request in writing that provides an update on your child's treatment plan. (You do **NOT** need to submit a new application.)

Assistance Requested

What financial assistance are you requesting? (Please check all that apply.):

☐ Transportation and/or Lodging (please complete pages 2, 3, and 4)
☐ Emergency Assistance Fund (please complete pages 2, 3, 4 and 5)

Patient Name _____

Consent to Release Information and Affirmation

I do hereby authorize all hospitals, financial institutions and insurance groups to release to the NCCS, or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize the NCCS and its representatives to provide such information to those institutions as may be reasonably required to assist our family and our child. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

In order to advance financial assistance in conjunction with the medical treatment of _____ (child), the undersigned do hereby affirm the following:

1. The undersigned are the parents or guardians of the child.
2. Financial assistance will be provided with the use of said funds to be specified by NCCS.
3. The undersigned further agree(s) to return any unused funds immediately to the NCCS so that those funds can be utilized by the organization to benefit other families.
4. The undersigned acknowledges(s) and agree(s) to maintain records that will be made available to the NCCS upon reasonable request, detailing the expenditures made from the funds provided by the organization.

The NCCS will pursue restitution for grants if it is determined that the information submitted on the application is false. I have read the guidelines for financial assistance and the eligibility checklist and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

Furthermore, the undersigned does hereby give continuing consent to NCCS to use images of any and all kinds of my child, myself, and our names, so long as they are only used on behalf of NCCS. I may void consent by scratching out this provision and initialing it.

Dated this _____ day of _____, in the year_____

_____	_____
Parent/Guardian Signature	Parent/Guardian Signature
_____	_____
Please Print Name	Please Print Name
Relationship to the patient/child:	Relationship to the patient/child:
☐ Mother ☐ Father ☐ Self	☐ Mother ☐ Father ☐ Self
☐ Grandparent ☐ Other _____	☐ Grandparent ☐ Other_____

Witness: _____

***We can only speak to the parent(s)/guardian(s) that have signed this application.**

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(314) 735-2014 (fax)

Please PRINT in black or dark blue ink and complete ALL sections accurately. If this is the first time a family is applying to the NCCS they MUST also complete the Transportation Assistance Fund Application (pages 2, 3 and 4).

Families who have a child that has been inpatient for 15 consecutive days (or away from home for 15 consecutive days to receive treatment) during the past 90 days are eligible for $300 in emergency assistance one time per fiscal year. Please see page 1 of the Application for Financial Assistance for additional eligibility guidelines.

Patient Name (first, middle, last) _____ ☐ Male ☐ Female

Date of Birth _____

Guardian Name(s)_____

Primary Phone # (_____) _____ ☐ Landline ☐ Cell

Secondary Phone # (_____) _____ ☐ Landline ☐ Cell

Email _____

Please consider sending a photograph of your child with the application or by email to pfs@theNCCS.org with name and date of birth.

Please check how you will utilize the assistance. If paying a bill, please include a copy of the bill to be paid.

- ☐ Mortgage
- ☐ Rent
- ☐ Utility Payment
- ☐ Child Care
- ☐ Health Insurance Premiums/COBRA
- ☐ Car Expenses
- ☐ Treatment Related Expenses (meals away from home, prescriptions, hospital parking, etc.)

Please describe how this assistance will help your family.

_____

_____

_____

Eligibility Confirmation (Please select one.)

- ☐ My child has been inpatient for 15 consecutive days during the past 90 days.
- ☐ My child has been away from home/relocated for 15 consecutive days during the past 90 days.

In order to receive emergency assistance, your application must include a letter from your social worker confirming your child's inpatient stay or relocation.

Funding Procedures:

1. A case manager will contact you by phone once the application has been received and processed by the NCCS to determine how we can best assist you.
2. Assistance is based on the availability of funds. You may apply for Emergency Assistance once per NCCS fiscal year (October 1 through September 30)
3. To reapply, you must continue to meet the eligibility guidelines after October 1 and 4 months must have passed since you were previously assisted by the NCCS Emergency Assistance Fund.