Joseph Michael Chubbuck Foundation (EIN 46-3739937)

PO BOX 4917 ROME, NY 13442

2020 Financial Assistance Application/ Consent Form

The JMCF provides assistance with out-of-pocket expenses not covered by insurance. Such as: utility & phone bills, rent, groceries, gas, lodging, tolls, cabs & bus fares, and medically necessary equipment/supplies. ***The JMCF DOES NOT PROVIDE ASSISTANCE FOR MEDICAL BILLS, CO-PAYS, OR NON-TRADITINAL MEDICINES & FOOD SUPPLEMENTS (SUCH AS HERBS, ETC.).***

TO QUALIFY FOR ASSISTANCE: The patient must be in active treatment (receiving chemo, radiation, targeted therapy, or having cancer surgery) AND the patient must live in or be receiving treatment in Oneida, Herkimer, Madison, or Onondaga Counties in Central New York State.***

TO CONFIRM: Patient/Guardian (if under 21) and the treating oncologist/radiologist OR oncology LSW must sign and submit this application. This gives the JMCF permission to verify that the patient is currently in *active treatment for cancer. *The JMCF will call the submitting physician's office or oncology LSW to verify the patient's eligibility for assistance as this ensures the appropriate use of funds.*

PROCESSING OF THE APPLICATION: The application requires (2) signatures: the patient or guardian (if under 21) & the treating oncologist/radiologist (*not their office staff)* OR oncology LSW. **If either signature is missing, then the application WILL NOT be processed.**

Once the application has been completed & has the required signatures, pages 2 & 3 of the application have to be sent to the JMCF by the treating physician or oncology LSW. The pages can be scanned and emailed to contact@thejmcf.org, faxed to 315-339-5993, or mailed to: JMCF PO Box 4917 Rome, NY 13442. *If you have questions or concerns please call the JMCF Office & leave a message at 315-339-5993 (M-F) from 9am to 5pm.*

ASSISTANCE ALLOCATED: Patients can receive up to $300/calendar year *(this total includes any funds given for gas assistance*). More assistance can be requested from the Board under emergency situations (maximum of $500).
Note: *the amount of assistance awarded will be based upon funds available at the time of the application's processing & the level of patient demand on the JMCF at the time of processing.*
Gas cards will be given to patients for gas assistance (*maximum per calendar year is $100)*.
Cab services, Bus services, utility & phone bills, and rent payments will be paid directly to the vendor/landlord on behalf of the patient.
Gift cards to major grocery store chains will be given to patients requesting grocery assistance. Assistance for needed medical supplies/equipment will be paid by the JMCF directly to the vendor on the patient's behalf OR gift cards to major drug stores may be requested by the patient. THE JMCF may issue foundation checks to assist patients under reviewed situations.

Application for Assistance

Please Circle the Area(s) below that you are seeking Financial Assistance with. List Amount Requested & Attach needed documentation (where indicated).

****Be sure to Email, Mail, or Fax REQUIRED Documents along with the Application or processing can not take place****

AREAS

Utility Bill(s) – FAX, Email, or Mail a copy of the bill(s) with your Application
(Foundation cap is $300 - see JMCF mailing address, Fax Number, and Email address on page 1)

Grocery – circle the store(s) you could accept a Grocery Card from:

Walmart *Hanaford* *TOPS* *Price Chopper*

ALDI **Amount Requested** *$*_____

Rent – state total amount of monthly rent _____*(Foundation cap is $300)*
Month/Date you would like rental assistance for: _____
Landlord Contact Info – Phone( ) _____
Landlord Name _____
Address _____
_____
_____

Gas Assistance – circle station(s) you could accept a Gas Card from:

CITGO *Stewarts* *Circle K* *Fast Trac*

SUNOCO *Speedway* **Amount Requested** _____
(max allowed is $100/year)

Hotel Expenses – (attach quote from hotel with contact info/dates or attach payment receipt if seeking reimbursement). **Same holds true for Toll Expenses.**

Cab/Bus Services – attach quote or provide contact info for service provider you will be using- along with Date(s) needed:

Name:_____Phone_____
Dates needed: _____

Medical Supplies/Equipment- attach quote, doctor's script or contact information for purchasing OR receipt(s) for reimbursement.

If you would like a drug store gift card for these needs indicate the store you wish to use & the item(s) you wish to purchase:

Drug Store Name _____

Item(s) _____

OTHER AREA *(Attach needed documentation):* _____

_____

PLEASE PRINT NEATLY & SIGN REQUIRED CONSENT AREAS

Date financial assistance is needed by _____

Name of Treatment Facility _____

Physician's Name _____

Physician's Address _____

_____

_____

Phone ( ) _____ Fax ( ) _____

Required * Signature Required of Oncologist, Radiologist, OR Oncology LSW (*not Office staff or Nursing Staff*

*Signature*_____ *Date* _____

Patient Name (printed neatly) _____

Address: _____

_____

Patient's Date of Birth _____

Contact Phone Number ( ) _____

Required *Patient Signature OR Guardian Signature (if under 21)

Signature _____*Date* _____

*****NO APPLICATION WILL BE PROCESSED WITHOUT A PATIENT'S SIGNATURE (GUARDIAN IF UNDER 21), PHYSICIAN'S SIGNATURE, & REQUIRED DOCUMENTATION (WHERE INDICATED)*****

The JMCF does not discriminate based on race, color, religion, sex, national origin, disability, or age. Informational Resources – To learn more about local/national resources that may offer assistance, please view the JMCF resources UNDER Resources tab at www.thejmcf.org.