# Joseph Michael Chubbuck Foundation (EIN 46-3739937)

**PO BOX 4917 ROME, NY 13442**

# 2024 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 (*currently *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:** The Patient (Legal Guardian if under 21 or not able to sign) and the treating oncologist/radiologist **OR** oncology LSW/treatment center's designee must sign and submit this application. The signature(s) give the JMCF permission to verify that the patient is currently in *active treatment for cancer. *The JMCF will call the submitting physician's office, oncology LSW, or designee to verify the patient's eligibility for assistance to ensure the appropriate use of donated funds.*

**PROCESSING OF THE APPLICATION:** *The application requires (2) signatures*: the patient or legal guardian's & the treating oncologist/radiologist (oncology LSW or treatment center's designee, *not general office staff). **If either signature is missing, the application WILL NOT be processed.***

**Once the application has been completed & has BOTH required signatures**, pages 2 & 3 must be sent to the JMCF. 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 9am to 5pm).*

**ASSISTANCE ALLOCATED:** Patients can receive up to $500/calendar year *(this total includes any funds given for gas assistance*). More assistance can be requested from the JMCF in emergency or other reviewed situations.
Gas cards will be given to patients for gas assistance (*maximum per calendar year is $200)*. 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 upon review of the circumstances.

**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. The JMCF is not responsible for lost or stolen gift card(s) once the card(s) has been placed in the mail & posted to the address provided on the application.*

# 2024 JMCF 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 cannot take place****

**Utility Bill(s)** – **FAX, Email, or Mail a copy of the bill(s) along with your Application**
*(Foundation cap is $500 - 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* *Hannaford* *ALDI* *Price Chopper*

*Grand Union* **Amount Requested** *$*_____
**Max $500 (but $300 if $200 in gas assistance is also requested)*

**Rent –**total amount of monthly rent _____*(Foundation will cap at $300-$500)*
Month/Date rental assistance is needed: _____
Landlord Contact Info – Phone( ) _____
*Landlord Name* _____
*Address* _____
_____
_____

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

*CITGO* *Stewarts* *Circle K* *SUNOCO* *Speedway* *Byrne Dairy*
**Amount Requested** _____ $50, $75 $100 (Max is $200/year)

**Hotel Expenses –** (**attach quote** from hotel with contact info/dates **or** if seeking reimbursement you must attach your receipt of payment to the hotel.
**Cab/Bus/UBER Services – attach quote or provide contact info** for service provider you will be using- along with Date(s) needed. *JMCF will pay the service provider directly or purchase an online UBER gift card (to be mailed to the patient, LSW, or treatment center designee) for patient use.*

Provider:_____Phone:_____
Dates needed: _____

**Toll Assistance- – (attach receipt of payment or proof of cost (quote).**

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

**Drug Store Gift Card**

Drug Store Name _____
Item(s) _____
Approximate cost _____ (if seeking reimbursement attach receipt).

**OTHER AREA** ***(List need & attach needed documentation):***

_____
_____

## PLEASE PRINT NEATLY & SIGN 2 REQUIRED CONSENT AREAS

**Date financial assistance is needed by** _____
**Name of Treatment Facility** _____
**Physician's Name at Facility** _____

**Physician's Address** _____
_____
_____

Phone (  ) _____  Fax (  ) _____

**Required * Signature Required of Oncologist/Radiologist, Oncology LSW, or Designee**

***Signature***_____ ***Date*** _____
***Your signature confirms this patient is in active treatment- "chemo, radiation, targeted therapy, cancer surgery" at this time (not in remission, not under observation, not on hormone prevention treatment).***

**Patient Name (print neatly)** _____
**Address:** _____
_____

**Patient's Date of Birth** _____
**Contact Phone Number** (  ) _____

**Required *Patient Signature (or legal guardian if under 21 or not able to sign)**
***Signature*** _____***Date*** _____

***NO APPLICATION WILL BE PROCESSED WITHOUT THE PATIENT'S SIGNATURE (LEGAL GUARDIAN IF UNDER 21 OR NOT ABLE TO SIGN) &* THE TREATING ONCOLOGIST/RADIOLOGIST (oncology LSW or treatment center designee) SIGNATURE. GENERAL OFFICE STAFF CAN NOT SIGN THIS APPLICATION. No application will be processed without the *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 resources that may you, please go to the www.thejmcf.org and click on "RESOURCES".