

Applicant Information

Full Name _____ Date _____
Last First M.I.

Address _____

Are you a full time resident? YES NO *If no, please explain:* _____

Phone _____ Email _____

Date of Birth _____ Age _____

Name of person completing form (if different from applicant) _____

What is the relationship of the person completing the form to the applicant?
 Self Spouse Child Other _____

Is the applicant currently undergoing active cancer treatments? YES NO
Please submit a note from a physician confirming this with your application

What are the types of expenses for which financial assistance would be used?

- Health insurance premiums
- Medical bills (deductibles, co-payments, co-insurance)
- Prescription medications
- Food
- Transportation expenses (e.g. vehicle fuels, repairs, etc)
- Rent or mortgage payments
- Utility bills
- Other: _____

Benefits Information

Do you have health insurance? YES NO

If YES, what type? MEDICARE MEDICAID PRIVATE OTHER

If NO, have you applied for Medicaid or other health insurance? YES NO

If you have applied, what is the status of that application? _____

Have you applied for Disability? YES NO

If you have applied, what is the status of that application? _____

Are you receiving SNAP benefits (food stamps), cash assistance and/or HEAP through the Department of Social Services? YES NO

If YES, what is the amount received for:

SNAP (food stamps) \$ _____
Cash Assistance \$ _____
HEAP \$ _____

If NO, have you applied? YES NO

If you have applied, what is the status of that application? _____

Income & Residency

Tell us about the applicant's living situation (please check all that apply)

OWN RENT STAY WITH FAMILY HOSPITAL/NURSING/OTHER FACILITY OTHER _____

Number of People in Household: _____
Monthly Household Income: \$ _____
Total Liquid Assets: \$ _____
(the sum of all dollars in cash, checking and savings accounts)

All Other Assets:
Retirement Accounts \$ _____
Properties (other than the primary residence) \$ _____
Stocks, bonds and investments \$ _____

Summary

Why are you applying for Financial Assistance at this time? Please briefly describe the financial hardship that you are experiencing.

Amount requested from the fund: \$ _____
Requests may be up to \$1,000 and are subject to the lifetime maximum award of \$2,000

With my signature below, I attest that all information provided on this form is true and accurate.

Signature of Applicant: _____ Date: _____

Complete and return to: Columbia County Community Healthcare Consortium, Inc.
Attn: R. Cole
325 Columbia Street Suite 200 Hudson, NY 12534

For Office Use Only

Determination of the Application Review Committee:
If assistance will be provided, what is the source?
CC Cancer Fund GC Cancer Fund Jan Koweek Fund Dyson Foundation Comp. Ther. Fund

If assistance will be provided, what is the associated P/O # _____

Instructions:

Please complete all highlighted sections of this HIPAA release form.

If any sections are left blank it will not be possible for us to process your application.

Name: _____

Date of birth: _____

I hereby request and authorize a release and free exchange of information between the Columbia County Community Healthcare Consortium and _____

*Name and address of provider or pharmacy
(a separate form must be completed for each provider or pharmacy)*

Please detail the reasons why information is being shared:

Time frame that information can be released to above mentioned:

From _____ to _____

I acknowledge the rights granted to me under HIPAA allow me to revoke this authorization at any time, provided that such revocation is in written format.

Signature of Individual

Date

Signature of Columbia County Community Healthcare Consortium Staff Member