Sue's Gift
Financial Aid Program

Our Financial Aid Program: The Sue DiNapoli Ovarian Cancer Society (SDOCS) is dedicated to supporting women in Colorado with ovarian cancer and gynecologic cancers. The Sue's Gift Financial Aid Program aims to help local women with expenses during cancer treatment.

Grants may be given to qualified applicants in the amount of $1000 per year for:

- Health insurance deductibles
- Medical expenses
- Psychiatrist visits
- Prescriptions
- Utility bills
- Rent or mortgage payments
- Car payments

The Sue's Gift program pays bills and does not award funds directly to individuals. Lifetime assistance limit total of $2000 per person. Yearly assistance limit is $1000 per person.

The Sue DiNapoli Ovarian Cancer Society grants assistance at its sole discretion. We review each application individually. Submission of an application is not a guarantee of assistance.

<u>To Qualify for Assistance</u>:

We offer financial assistance to ovarian cancer and gynecologic cancer patients if the applicant meets the residency, medical and financial qualifications listed below.

<u>Residency:</u>

1. Financial assistance is available to residents of the southern half of the state of Colorado. (Proof of residency is required with application.)

2. Financial assistance is available to Colorado residents state-wide for those participating in the Woman to Woman peer support program.

<u>Medical:</u>

You must be diagnosed with ovarian cancer, fallopian tube cancer, cervical cancer, uterine cancer, peritoneal cancer, vulva or vaginal cancer and currently be in chemotherapy or other oncologist-directed treatment for gynecologic cancer OR have completed surgery or treatment for gynecologic cancer within the last three months. You must provide verification of your medical status from your oncologist (see application).

Financial:

1. Your monthly household expenses must be more than your monthly household income (defined as income received from patient and their domestic partner, regardless of gender), and your total household income must be less than or equal to 300% of the HHS Federal Poverty Level (see attached). In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your county. (www.huduser.org)

2. Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.

You may be asked to provide additional paperwork to SDOCS in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, SDOCS has the right to withdraw your application, stop all assistance and take steps to recover previous awards.

Follow these steps below to apply for assistance.

Step 1: Fill out the Sue's Gift Application pages 1 – 4. Use the Federal Poverty Level attachment to check your income level for eligibility (equal to or less than 300% FPL for your family size).

Step 2: Detach the Sue's Gift Medical Verification form (page 5). Take to your Oncologist's office. Have them fill it out and make a copy using their letterhead. Return to SDOCS by mail or email.

Step 3: Make a copy of your current Colorado Driver's License, Colorado-issued I.D. **or** other proof of residency with an address matching your application (e.g. utility bill, etc.), and include with your application.

Step 4: Mail your completed application and all required attachments to:

Sue DiNapoli Ovarian Cancer Society
Attn: Sue's Gift
915 Pinon Ranch View #6
Colorado Springs CO 80907

**For quicker processing, you may email the application to sherrymartinco@gmail.com or fax it to 719-264-1094. Please be sure to provide all the information requested here. An incomplete application will delay our ability to provide you with assistance.

Once SDOCS receives your application, the Sue's Gift financial aid committee will review it. Once a decision is made, an Agreement or Decline letter will be sent to you by mail or email. If your application has been accepted, you will be contacted to determine how to proceed with bill payment.

This is also a time to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact: Sherry Martin, Patient Services Director at 719-505-2879 or sherrymartinco@gmail.com

Sue's Gift Application

Personal Information

Last Name________________________First Name______________________Middle Initial_____

Address______________________________ City________________State______Zip___________

County_____________Date of Birth ___________ Email address______________________________

Phone: Home __________________ Mobile__________________ Work __________________

Best way to reach you: (circle one) Home Phone Cell Phone Work Phone Email

Best time to reach you: (circle one) Morning Afternoon Evening Best hours:____________

Marital Status: (circle one) Single Married Partnered Separated Divorced Widowed

Additional Contact Person:

Name______________________________Relationship________________Phone_______________

Do you have health insurance? _____Yes _____No If yes, please indicate type of insurance:

(check all that apply) _____Private insurance _____Medicare _____Medicaid _____ VA _____ Other

If private insurance, please name insurance company ____

Comments: ____

Are you currently working? _____Yes _____No If yes, how many hours per week? _____________

Were you working before your cancer diagnosis? _____Yes _____No

Total # in household__________ # of wage-earners in home__________ # of dependents__________

Who referred you?____________________________ Referring person's phone___________________

Referring person's email ____

Have you received Sue's Gift before? _____Yes _____No If yes, what year?_______________

Are you participating in the Woman to Woman peer support program? _____Yes _____No

Name: ______________________________

Sue's Gift Application

Page 2

Income Information
(Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.)

TOTAL CURRENT MONTHLY INCOME: $_____________
Please list details below:

Wages

Your wages after payroll taxes $_________________________
Spouse or partner's wages after payroll taxes $_________________________
Other income from wages or self-employment $_________________________

Income from Benefits & Insurance

Employer disability insurance $_________________________
Unemployment insurance $_________________________
Retirement / Pension $_________________________
401K / IRA income $_________________________
Social Security $_________________________
SSI / SSDI $_________________________
Other benefits/Insurance $_________________________
Income from assistance alimony / Child support received $_________________________
Low-Income Energy Assistance Program (LEAP) $_________________________
Food Stamps (SNAP) $_________________________
Temporary Aid to Needy Families (TANF) $_________________________
Aid to the Needy and Disabled (AND) $_________________________
Section 8 from HUD (housing supplement) $_________________________
Help from family members $_________________________
Help from religious / faith community $_________________________
Help from friends $_________________________
Help from other nonprofit organizations $_________________________
Other Assistance $_________________________

Assets	**Monthly Income From**
Cash / Checking Value: ________________________	$_________________________
Savings Value: ________________________	$_________________________
Life insurance value: ________________________	$_________________________
Investments value: ________________________	$_________________________
Retirement funds value: ________________________	$_________________________
Other assets value: ________________________	$_________________________
Real estate value: ________________________ (not the house you live in)	$_________________________

Name: ______________________________

Sue's Gift Application

Expenses Information

TOTAL CURRENT MONTHLY EXPENSES: $____________

Please list details below:

Household Expenses

Rent $______________________________
Mortgage $______________________________
Energy bill $______________________________
Water bill $______________________________
TV / Internet / Cable / Satellite $______________________________
Telephone / Cell (including long distance) $______________________________
Food $______________________________

Dependent Expenses

Child care $______________________________
Child support paid $______________________________
Elder care $______________________________

Transportation Expenses

Car payment $______________________________
Gasoline $______________________________
Car insurance $______________________________
Parking / Public transportation $______________________________

Medical Expenses

Health insurance premiums $______________________________
Medical costs (after insurance) $______________________________
Medication costs (after insurance) $______________________________

Loan Expenses

Loan payments $______________________________
Credit card payments $______________________________

Other Expenses

Other:______________________$______________________________
Other:______________________$______________________________
Other:______________________$______________________________

Are you currently seeking any assistance or debt relief for outstanding expense payments? Please explain:

____

____

Name: ______________________________

Sue's Gift Application

GYNECOLOGIC CANCER HISTORY

Date Diagnosed____________ Type of Gynecologic Cancer_________________________ Stage___________

Have you experienced a recurrence? ___________ Have you seen a Gynecologic Oncologist?___________

Have you participated in a clinical trial?___________

Surgeon _____________________________ Oncologist ______________________________

Social Worker___________________________ Nurse / Navigator______________________________

Physician completing the Medical Verification____________________Facility____________________

Please check your reason for applying for Sue's Gift Financial Aid:

_____ To help pay an annual health insurance deductible
_____ To help pay for a prescription
_____ To help pay for a psychiatrist
_____ To help pay for other medical expenses
_____ To help pay housing expenses (rent or mortgage)
_____ To help pay for utilities
_____ To help pay for car payments

Read and check the lines to verify the following information:

_____I have read Page 1 and understand how and who Sue's Gift helps with financial assistance.
_____I live in Southern Colorado.
_____I am participating in the Woman to Woman peer support program.
_____I have enclosed proof of residency.
_____I am currently undergoing chemotherapy or other oncologist-directed treatment for gyn cancer.
_____I am currently within three months of gynecologic cancer-related surgery, chemotherapy, or oncologist-directed treatment.
_____I have signed the bottom of this page, which serves as a medical release giving SDOCS permission to obtain the necessary medical information to process my application.
_____I understand that SDOCS will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview.
_____I understand that the Sue DiNapoli Ovarian Cancer Society provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release SDOCS from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize SDOCS to release any information including my name, address, and type of assistance provided to any other social service agency at SDOCS's discretion. I also authorize the release of any medical information and documentation required by SDOCS for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.

Applicant's Signature______________________Print Name_____________________Date: ________

Healthcare Provider: Please copy this form onto your official office letterhead, complete and mail, scan/email, or fax to Sue DiNapoli Ovarian Cancer Society. Thank you for your assistance.

Mail: Sue DiNapoli Ovarian Cancer Society – Attn: Sue's Gift
915 Pinon Ranch View #6 / Colorado Springs, CO 80907
Email: sherrymartinco@gmail.com
Fax: 719-264-1094

Sue's Gift Medical Verification

Patient name ______________________________Confirmed diagnosis_____________________________

Date of initial diagnosis __________Stage__________Cell type___________________ Grade_________

Patient is currently seeing a Gynecologic Oncologist: ____Yes____No Name ________________________

Patient is currently seeing a Medical Oncologist: ____Yes____No Name ________________________

Patient is currently being treated for a recurrence: ____Yes____No Recurrence date_______________

Patient is currently undergoing chemotherapy: ____Yes____No

Chemotherapy start date__________________ Anticipated end date________________________

Drug ____________________________________ Drug ___________________________________

Drug ____________________________________ Drug ___________________________________

Patient has undergone surgery: ____Yes____No Most recent surgery date ________________

Patient has a planned surgery: ____Yes____No Planned surgery date __________________

Surgical procedure ____

Patient is being admitted to a clinical drug trial: ____Yes____No

Clinical trial start date ______________________ Anticipated end date___________________

Other planned treatment(s) or important medical information about this patient's gynecologic cancer treatment:____

____

____

Referring professional completing this form: (Physician, PA, NP, Nurse, Navigator or medical LCSW)

Name & credentials ______________________________ Hospital/Clinic __________________________

Address ____ City ______________________________

State ________Zip_________Phone (   )________________Email______________________________

My signature below affirms the diagnosis and treatment information as described on this page.

Referring professional signature____ Date: ___________

Oncologist signature ____ Date: ___________