The Incyte Cancer Care Assistance Fund for Delaware

The *Incyte Cancer Care Assistance Fund for Delaware* is an emergency fund that was established by Incyte Corporation for the sole purpose of providing emergency financial assistance to people with cancer, their caregivers and family members who reside in Delaware. This fund is administered entirely by Cancer Support Community Delaware and open to cancer patients who demonstrate financial need and who are either receiving active treatment or have recently received treatment for any type of cancer.

The fund will provide financial assistance for medical expenses and/or basic living expenses on behalf of cancer patients who demonstrate financial need because of their illness and their treatment. Expenses considered include, but are not limited to, medical bills, co-pays, scans, and testing, as well as rent, mortgage, utilities, phone, transportation, groceries and childcare.

Guidelines:

- Applicants must reside in Delaware, regardless of where they are receiving treatment.
- Applications will be considered for cancer patients with demonstrated need both before, during and up to one year after treatment.
- Confirmation of a cancer diagnosis and treatment must be provided by a treating physician on the applicant's medical team.
- Applicants must demonstrate a clear financial hardship and the inability to pay medical bills and/or current living expenses.
- Payments will be made directly to service providers – no funds will be given directly to patients or their families.
- Applicants may apply for assistance up to three times in one calendar year; however, if funds are limited at the time of application, priority will be given to first-time applicants.

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Application

NAME: _____ DATE OF BIRTH: ____/___/____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

RACE/ETHNICITY: (please note: this question is optional – should you choose to complete, answers will remain confidential – information gathered may be used to secure further funding for outreach programs at CSCDE)

_____ CAUCASIAN **_____ AFRICAN AMERICAN** **_____ OTHER**

_____ HISPANIC **_____ NATIVE AMERICAN**

_____ ASIAN **_____ PACIFIC ISLANDER**

REFERRED BY: _____

HOSPITAL/CANCER CENTER WHERE APPLICANT IS BEING TREATED:

_____

TREATING PHYSICIAN'S NAME AND PHONE NUMBER:

_____

NAME, ADDRESS & PHONE NUMBER OF APPLICANT'S EMPLOYER:

_____

_____

MEDICAL INFORMATION

CANCER DIAGNOSIS: _____

DATE OF DIAGNOSIS: ___/_____/_____ INITIAL DIAGNOSIS? _____Y_____N

-TYPE: _____ -STAGE: _____

-SURGERY: _____-TREATMENT: _____

_____ _____

INSURANCE INFORMATION (INCLUDE MEDICAID)

NAME OF PRIMARY INSURANCE COMPANY/INSURER: _____

NAME OF SECONDARY INSURANCE COMPANY/INSURER: _____

ARE YOU THE INSURED? _____Y _____N

IF YOU ARE A DEPENDENT, NAME & RELATIONSHIP OF INSURED _____

ANNUAL DEDUCTIBLE: _____

CO-PAYS (IF APPLICABLE):_____

PERSONAL STATEMENT

Please describe, briefly, your financial situation and how your cancer diagnosis and treatment has caused you financial hardship.

Please describe the specific medical or living expenses for which you are requesting assistance.

FINANCIAL INFORMATION

ARE YOU CURRENTLY EMPLOYED? ___Y ___N

TOTAL NUMBER OF DEPENDENTS IN HOUSEHOLD: _____
(CHILDREN/SPOUSE/PARENTS)

TOTAL NUMBER OF WORKING ADULTS IN HOUSEHOLD: _____

COMBINED HOUSEHOLD INCOME	**BEFORE DIAGNOSIS**	**AFTER DIAGNOSIS**
NET MONTHLY SALARY:	_____	_____
SOCIAL SECURITY:	_____	_____
DISABILITY: (SHORT OR LONG TERM)	_____	_____
OTHER:	_____	_____

EXPENSE INFORMATION

TYPE	PROVIDER/COMPANY	AMOUNT DUE	DUE DATE	AMOUNT REQUESTED
MEDICAL (INCLUDE ALL MEDICAL EXPENSES – DOCTORS, TESTING, CO-PAYS, ETC. – PLEASE USE ADDITIONAL PAPER, IF NECESSARY)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
RENT/MORTGAGE:	_____	_____	_____	_____
CELL PHONE:	_____	_____	_____	_____
ELECTRIC:	_____	_____	_____	_____
GAS/OIL:	_____	_____	_____	_____
PHONE/INTERNET:	_____	_____	_____	_____
OTHER:	_____	_____	_____	_____

TOTAL AMOUNT REQUESTED (ATTACH SUPPORTING DOCUMENTS): _____

I hereby certify, under penalty of perjury, that the information set forth on this application concerning my income, liabilities and insurance provider is true and accurate and that the expenses for which I have requested financial assistance impose a financial hardship for me. Further, I have been diagnosed with cancer, I am undergoing treatment for, or I have recently undergone treatment for cancer, and I do not have adequate resources or income to pay for the expenses. I understand that if any of the information set forth above is false, that my application will be null and void.

By signing below, I hereby grant and give permission for representatives of Cancer Support Community Delaware to contact my physician(s) and/or medical team member(s) as needed.

Signature: _____ Date: ___/___/___

Cancer Support Community Delaware
Attn: Executive Director
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Wilmington, DE 19807
Phone: 302.995.2850
Fax: 302.995.0834