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 basic living expenses and/or medical expenses on behalf of cancer patients who demonstrate financial need as a result of their illness and their treatment. Expenses considered include, but are not limited to medical bills, co-pays, scans, and testing, 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.
- An incomplete form will not be reviewed by the committee. For all fields that do not apply to you, please write “N/A”.
- 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 re-apply after 3 months, but must fill out the addendum (last page of this application) and provide current bills.
- Applicants can apply a maximum of 3 times.
- Maximum an applicant may receive in total funds is $3,000.

The Incyte Cancer Care Assistance Fund for Delaware
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: _______________________________________

-Briefly describe surgery related to your cancer, including date performed or expected.____

____

-Briefly describe treatment plan (chemotherapy, radiation, etc.).____

____

INSURANCE INFORMATION

NAME OF SECONDARY INSURANCE COMPANY/INSURER: ________________________________

ARE YOU THE INSURED? _____Y _____N

IF 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

List all expenses you are asking for assistance with, and provide copy of bill you wish to be paid. Bill must show your name and address, total due, and name and address of who the bill should be paid to.

TYPE	PROVIDER/COMPANY	AMOUNT DUE	DATE DUE
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:	___________________________	__________	________

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
4810 Lancaster Pike
Wilmington, DE 19807
Phone: (302) 995-2850
Fax: (302) 995-0834
npickles@cscde.org

The Incyte Cancer Care Assistance Fund for Delaware
Application Addendum

This page to be filled out when re-applying for funds.
Please also provide copies of updated bills

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

ADDRESS: ____

____

HOME #: __________________ CELL #: _____________________ EMAIL: _________________________

DATE PREVIOUSLY APPLIED: _________________________ AMOUNT AWARDED:____________

UPDATED PERSONAL STATEMENT

Please update us on your cancer diagnosis and current treatment.

____

____

____

____

____

Please provide an updated statement on your financial situation and how your cancer diagnosis and treatment has caused you financial hardship.

____

____

____

____

____

EXPENSE INFORMATION

List all expenses you are asking for assistance with, and provide copy of bill you wish to be paid. Bill must show your name and address, total due, and name and address of who the bill should be paid to.

TYPE	PROVIDER/COMPANY	AMOUNT DUE	DATE DUE
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:	____________________	__________	________