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 purpose of providing emergency financial assistance to people with cancer who both reside in Delaware, and are U. S. citizens. This fund is administered by Cancer Support Community Delaware and is available to cancer patients who demonstrate financial need, who are in active treatment, or have recently received treatment for cancer.

The fund may provide for basic living expenses and/or medical expenses for eligible cancer patients. Expenses considered include, but are not limited to, rent, mortgage, utilities, medical bills, co-pays, scans, and testing.

Guidelines:

- Applicants **must reside in Delaware and be U. S. citizens**, regardless of where they are receiving treatment.
- Applicant must currently be in **active treatment, or within a year from completing active treatment**. Active treatment includes surgery to remove tumors, chemotherapy, immunotherapy, and radiation. (Post treatment regimens such as endocrine therapy (tamoxifen, arimidex, anastrozole, etc) and plastic surgeries do not qualify as active treatment.)
- Applicants must demonstrate **a clear financial hardship during treatment**, and the inability to pay for current living expenses and/or medical bills.
- The application form must be **filled out completely**. (if questions do not apply, please write "N/A")
- **Confirmation of a cancer diagnosis** and treatment must be provided by a physician, or other medical professional on the applicant's medical team.
- **Payments will be made directly to service providers** – no funds will be given directly to patients or their families.
- Applicants may only apply for assistance **one time**. Once applicant is assisted, or applicant is denied due to not meeting criteria, they may not apply again.

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APPLICATION

NAME: _____ DATE OF BIRTH: _____/_____/_____
ADDRESS:
_____

HOME PHONE: _____ CELL PHONE: _____
EMAIL: _____
REFERRED BY: _____
TODAY'S DATE: _____/_____/_____
HOSPITAL/CANCER CENTER WHERE APPLICANT IS BEING TREATED:
_____

TREATING PHYSICIAN'S NAME AND PHONE NUMBER:
_____

MEDICAL INFORMATION

CANCER DIAGNOSIS (type, stage if known):_____
DATE OF DIAGNOSIS: _____/_____/_____ INITIAL DIAGNOSIS?
_____Y_____N
Briefly describe surgery related to your cancer, including date performed or expected:_____
_____
_____
_____
_
Briefly describe treatment plan (chemotherapy, radiation, etc.):
_____
_____
_____
_____

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY/INSURER:
_____
NAME OF SECONDARY INSURANCE COMPANY/INSURER:
_____
ARE YOU THE INSURED? _____Y _____N
IF DEPENDENT, NAME & RELATIONSHIP OF INSURED:
_____

PERSONAL STATEMENT

Briefly describe your financial situation and how your cancer diagnosis and treatment have caused you financial hardship (give as much specific information as possible, including current and future employment situation) :

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

FINANCIAL/INCOME INFORMATION

ARE YOU CURRENTLY EMPLOYED? _____Y _____N

If Yes, who is employer? If No, where did you previously work and what are your future employment plans?

_____
_____
_____

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

TOTAL NUMBER OF WORKING ADULTS IN HOUSEHOLD:
_____(Spouse/Child/relative)

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

EXPENSES

List all expenses you are asking for assistance with and **provide legible copy of bill(s) you wish to be paid. Bills must show the payment coupon, your total name and address, total due, and total name and address of payee**. Screen shot of a current bill in not acceptable, it must be an invoice.

TYPE	PROVIDER/COMPANY	AMOUNT DUE	DATE DUE
RENT/MORTGAGE:	_____	_____	_____
ELECTRIC:	_____	_____	_____
GAS/OIL:	_____	_____	_____
PHONE/INTERNET:	_____	_____	_____
CELL PHONE:	_____	_____	_____
OTHER:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
MEDICAL:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

CERTIFICATION OF INFORMATION PROVIDED

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 reside in Delaware, and I am a citizen of the United States.

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 of applicant: _____Date: _____/_____/_____

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