



The HOPE CHEST for WOMEN helps patients with significant financial need defray treatment-related expenses, including approved medications, chemotherapy, radiation therapy, transportation, and testing not covered by insurance or other sources.

Through this program, financial assistance, relevant education, and support services are offered to medically underserved women who are in need of support during treatment for cancer.

Scholarships are available for educational classes and survivorship summits.

Who is Eligible for Assistance?

You may qualify for assistance through the Hope Chest Financial Aid Program if you:

- are a woman receiving treatment for breast, cervical, endometrial, ovarian, uterine, vaginal, or vulvar cancer
- reside in western North Carolina
- are uninsured, underinsured, or need financial assistance

If you have private insurance, you may receive aid for treatment-related costs that are not covered through other payment sources.

Other eligibility requirements will apply.

Required documents include Hope Chest application, proof of income, pathology report and (if applicable) letter of medical necessity, and a copy of bill(s) to be considered for payment.

Submit your application to
The Hope Chest for Women
P. O. Box 16948
Asheville, NC 28816

If your application is approved and you receive aid:

Payments will be made to providers of service (i.e. pharmacy, lab, hospital, physician).

Funds are subject to availability.

All decisions for disbursements to eligible patients are
at the discretion of The Hope Chest board.



2012 Assistance Application

Patient Information

Please complete all information and print legibly.

First Name: _____ MI _____ Last Name: _____

Social Security/Green Card #: _____ Birth date: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

E-Mail Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Diagnosis (Type of cancer): _____ Physician (Oncologist): _____

Date of diagnosis _____ Current treatment _____

Insurance Information

(Please complete if you have insurance coverage.)

Insurance Company: _____ ID Number: _____

Do you have a drug plan? Yes No Type of plan: _____

Do you receive state assistance? Yes No Do you receive assistance from other sources? Yes No

If yes, please list: _____

Financial Information

List all sources of monthly income for yourself and persons in the household.

Total Monthly Net Family Income: \$ _____ Total Family Liquid Assets: \$ _____

Average Monthly Out-of-Pocket Medical Expenses: \$ _____

Number of people in the household: _____ Current employment status: _____

Funding Request

What kind of assistance do you need? Please be specific: _____

Who referred you to The Hope Chest? _____ Phone: _____

Please include required documents (see cover letter) and any applicable information with this form.



Information Release Statement

I attest to the above information being correct and complete to the best of my knowledge. By my signature, I authorize the release of the above information to The Hope Chest and I authorize The Hope Chest to use the above information to contact my insurer, other potential funding sources, social workers, or patient advocacy organizations on my behalf to determine my eligibility for alternative financial support through The Hope Chest.

I also authorize The Hope Chest to contact my insurer, health care provider, or dispensing agent, and I authorize aforementioned entities to disclose information to The Hope Chest, relative to my medical condition, treatment or drug therapy as requested by The Hope Chest. Disclosure of this information may include, but is not limited to, the electronic transmission of information. The Hope Chest agrees to request only that information needed to process this application, to renew it, and to provide continued assistance during my participation in the program. The Hope Chest also agrees not to disclose any information obtained from these sources to any third party except as authorized by me or as required by applicable law.

This authorization shall continue in effect until final decisions have been made regarding this application. I also understand that submitting this application does not guarantee financial or other support from The Hope Chest.

Patient's Signature _____ **Date** _____

If you have questions, please call (828) 418-1344.