The HOPE CHEST for WOMEN helps patients with significant financial need defray treatment-related expenses including; incidental costs not covered by other assistance programs, transportation, supplements, lymphedema garments, testing approved medications, chemotherapy, and radiation therapy 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.

Who is Eligible for Assistance?

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

- reside in western North Carolina
- are a woman receiving treatment for breast cancer
- are you receiving treatment for cervical, endometrial, fallopian tube, ovarian, uterine,
- vaginal, or vulvar cancer
- are uninsured, underinsured, or need financial assistance
- must provide doctor pathology report

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

All Required documents must be submitted with your application to receive assistance. Please send all of these items listed below in order to expedite your application.

- Hope Chest Application
- Information Release Statement
- Income Statement is needed from every applicant (Copy of recently filed taxes, most recent pay stub, retirement or disability statement or bank statement) Level of income will not disqualify you for help.
- Pathology Report and Progress Notes
- Letter of Medical Necessity, if applicable
- A copy of bill(s) with payment instructions must be sent to us in order to provide bill pay assistance, payment could take over two weeks for approval.

Submit your application to
The Hope Chest for Women
P.O. Box 5294
Asheville, NC 28813

Your application will be approved after all supporting documents are submitted. Payments will be made to providers of service (i.e. pharmacy, lab, hospital, and physician). Funds are subject to availability. A new application is required every calendar year with supporting documentation. You will be given additional resource referrals based on your individual needs.

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

* P. O. Box 5294 * Asheville, NC 28813 * (828) 708-3017 * Fax (828) 348-6164

The Hope Chest for Women 2023 Assistance Application
Please complete ALL information and print legibly.

Patient Information

First Name: _____MI _____ Last Name: _____ Last 4 of SS#_____

Birth date: _____ Age: _____ Ethnicity: _____

Mailing Address: _____

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

Street Address (if different): _____

E-Mail Address: _____

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

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

Date of diagnosis: _____ Stage at diagnosis: _____

Current treatment:

_____

_____

Insurance Information

Insurance Company: _____ ID Number: _____

Do you have a prescription 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 and Household Information

Total Monthly Net Family Income: $_____ Total number in household: _____

Number of Adults: _____

Total Family Liquid Assets: (not car) $_____ Number of Children: _____

Ages of Children: _____

Out-of-Pocket Medical Expenses: $_____/month Current Employment Status: _____

Funding Request

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

_____

_____

_____

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

I attest to the above information being correct and complete to the best of my knowledge.

_____ _____

Applicant Signature **Date**

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

Revised – Jan 2018

The Hope Chest for Women

Information Release Statement

By my signature, I authorize the release of the information provided on my application to The Hope Chest and I authorize The Hope Chest to use same 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 understand that submitting this application does not guarantee financial or other support from The Hope Chest**.**

Applicant's Name: _____ Date: _____

Signature

_____

Print Name

I also grant permission for The Hope Chest to discuss my application with the following:

1._____ _____

Name **Relationship**

2._____ _____

Name **Relationship**

May we leave a message on your answering machine or cell phone? Yes_____ No_____

I authorize the following to be released:

- Pathology Report(s)
- Most Recent Progress Notes

TO: **FROM:**

The Hope Chest for Women, Inc._____

P. O. Box 5294_____

Asheville, NC 28813_____

_____ _____

Printed Patient Name Date of Birth

_____ _____

Patient Signature Date Signed