A Local (501) (c) (3) Charity serving Cancer Patients in Tallapoosa County, Alabama

"Assisting Patients through their "Journey to Recovery"

Assistance Request Application

Tallapoosa's Caring "REFUGE" Mission Statement:

To assist Cancer Patients who are citizens of Tallapoosa County that are currently undergoing debilitative cancer treatments by providing temporary financial assistance for basic needs such as medicine, Co-pays rent/mortgage and utilities, travel and/or other identified needs.

The basis for this critical assistance will come from corporate donations, private donations, grants and certain fundraising efforts. Patients are chosen through a selection process that addresses specific needs. Once a recipient is chosen, funds will be disbursed directly to the vendor or supplier of these identified needs based on the availability of funds. Our goal is to assist these patients in winning their battle against cancer. Our intent is that by diminishing financial stress related to the basic needs of the family, patients can direct their energies more effectively to the healing process.

** Policy & Eligibility Guidelines for Assistance**

Our objective is to assist as many Tallapoosa County cancer patients as possible. To ensure this, we have established certain policies and guidelines. (These guidelines will be reviewed and updated annually by our Board of Directors).

General Requirements

1. Must be a resident of Tallapoosa County.
2. Must have active cancer diagnosis and receiving active treatment. We understand people choose to refuse chemo and other drugs. (Diagnosis Confirmation Form and application must be completed and signed by both the Patient and treating Physician).
3. Applications will be reviewed by Tallapoosa's Caring "REFUGE" Board of Directors.
4. Applicants may re-apply for assistance every 90 days from the date of award notification. If denied, cancer patient may re-apply after 30 days from date of notification letter.

Contact Tallapoosa's Caring "REFUGE" to re-apply.

2036 Cherokee Road, Suite 25 Alexander City, AL or email tcrefuge@yahoo.com

Procedure for Assistance Request

1. Complete and submit the Application for Assistance Request Form and all required attachments.
1. Applications will not be considered complete and reviewed until ALL supporting documentation is received or an explanation is received explaining any missing documents.
2. Complete the patient portion of the Diagnosis Confirmation Form and submit to your current treating physician's office. The doctor will send the Diagnosis Confirmation Form directly to Tallapoosa's Caring "REFUGE".
3. The Board of Directors will review all applications for assistance and will make final selection based on availability of funds.
4. Selected applicants will be notified within 10 days once assistance is approved.
5. Applications will only be accepted by mail or email or in person.

** PATIENT CHECKLIST**

Completed Application

- Sign and Complete Disclosure of Protected Health Information
- MAIL, email or fax Application & Documents
- Verify Doctor has Mailed or Emailed the Diagnosis Confirmation form.
- Mail to Tallapoosa's Caring "REFUGE" 2036 Cherokee Road, Alexander City,35010 or email to tcrefuge@yahoo.com or call 256-496-1484 for assistance with completion and pickup.'
- The Board of Directors for Tallapoosa's Caring "REFUGE", reserves the right to request a copy of financial documents such as pay stubs and bank statements if deemed necessary.

** Application for Assistance Request**

Date _____/______/_____

Applicant's Name ________________________ Date of Birth___ ____________

Mailing Address ____

County _______________

Phone __________________ Other Phone __________________

Contact Person: (If Other than Patient) and how they are related. _______________________
Mailing Address: _____________________________

Phone: ___________________

**Name of Mortgage Co/Landlord_______________________________

Address ____

Amount of Mortgage or Rent ____________ Number of payments past due :_________

Account Number ______________________ Phone Number_______________________

If selected for an award, in what order would you like any award applied (Co-pays, Medicine, travel expense, rent/mortgage, electric, gas, water.) Attach invoice for expense that is chosen.

1) ________________ 2)______________3)_________________4)_________________

Are you currently receiving assistance from other organizations? Y or N. If so list.

Have you met with hospital social worker to see if they offer assistance such as grants for medicine?

Please include a brief statement telling us about your personal situation. Include any information you feel is pertinent to your application and why you need our help.

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How did you hear about Tallapoosa's Caring "REFUGE"? ____

I understand that my application cannot be processed until I have completed all of the documentation and submitted it to the address noted on the bottom of this application.

By signing below, I agree that the information provided above and in the attachments is accurate to the best of my knowledge. I further understand that my name and personal/financial information will be kept confidential unless I give specific permission otherwise.

Applicant's Signature: _________________________________ Date:_____/_____/_____

Contact any Board Member for assistance.

Mailing address Tallapoosa's Caring "REFUGE", 2036 Cherokee Road, Suite 25 Alexander City, Al 35010. Or email tcrefuge@yahoo.com , Phone – 256-496-1484

Any Board member will be glad to assist with completion or make arrangements to drop off and pick up the application if needed.

Diagnosis Confirmation Form

Applicant's Name: ____

Complete Mailing Address: ____

Date of Birth: ________________

I hereby authorize __________________________ (Name of Current Treating Physician) to release or disclose to Tallapoosa's Caring "REFUGE" my medical information pertaining to my current diagnosis and prognosis, surgeries and treatments. I further authorize you to discuss with Tallapoosa's Caring "REFUGE" any confidential information with respect to my medical condition or treatment and any confidential information with respect to my financial situation. I understand the purpose of this disclosure is for use in pending application for financial assistance by Tallapoosa's Caring "REFUGE". I understand that my name, personal, financial and medical information will be kept confidential unless I give specific permission otherwise. This authorization will expire one year after the date of signature below.

Applicant's Signature:_____________________________________ Date:_____/_____/_____

Patient fills out top portion of form and gives to current treating physician

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Physician fills out bottom portion of form and mail form to Tallapoosa's Caring "REFUGE" address: 2036 Cherokee Road, Suite 25 , Alexander City, AL 35010

Type of Cancer____

Date of Initial Cancer Diagnosis _____/_____/_____/ Date of Surgery _____/_____/_____

Chemo Start Date _____/_____/_____ Chemo End Date ____/_____/_____/

Radiation Start Date _____/_____/_____ Radiation End Date _____/_____/_____

Treating Physician Name: ____

Complete Address: ____

Phone Number: _______________________

Physician Signature: _______________________________________ Date_____/_____/_____

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