Cancer Association of Greater New Orleans
824 Elmwood Park Blvd. Suite 154
New Orleans, LA 70123-3342
(504) 733-5539 or (800) 624-2039 Fax: (504) 733-0252

SUSAN G. KOMEN LOUISIANA GRANT – Breast Cancer Patients only

PLEASE READ CAREFULLY AS OUR GUIDELINES AND APPLICATION HAVE CHANGED

The Cancer Association of Greater New Orleans- CAGNO, through a generous grant from Susan G. Komen Louisiana Affiliate, is able to offer services in the following parishes: Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Ouachita, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Helena, St. James, St. Landry, St. Martin, St. Mary, Tangipahoa, Tensas, Terrebonne, Union, Vermillion, Vernon, Webster, West Baton Rouge, West Carroll, West Feliciana, and Winn.

2020 – 2021 Eligibility Guidelines

In order to apply for assistance**,** you **must** submit a new application. Submitting a new application does not automatically qualify you for continued assistance.

The services provided by CAGNO are only available to cancer patients, currently in treatment and under the care of a Hematologist/Oncologist, for their cancer diagnosis.

Please provide the following documents from each applicable section listed below:

- Proof of Identity required: (one required)

  - ✓ Current state ID or Driver's License
  - ✓ Current Military, employee or school ID
  - ✓ Valid Passport/Immigration documents

- Patients who file income tax must submit a copy of their current federal tax return (Form 1040, 1040A, or 1040EZ). Patients who also receive Social Security Retirements, Social Security Disability income or Supplemental Security Income must provide this documentation if it is not stated on the tax return. Spouses' social security income documentation must also be provided. Examples of social security documentation include: (provide all that apply)

  - ✓ Social Security determination letters
  - ✓ Copies of Social Security checks
  - ✓ 1099 forms
  - ✓ Bank statements indication a social security deposit

- Patients who **do no file income taxes** are required to provide proof of household income. Proof of current household income must be provided for both patient and spouse. Examples of proof of household income are: (provide all that apply)

  - ✓ Social Security determination letters
  - ✓ Copies of Social Security checks
  - ✓ 1099 forms
  - ✓ Bank statements indicating a social security deposit
  - ✓ Food stamp budget slip or Louisiana Purchase card

- ✓ Medicaid card or proof of free care

- If patient's household income has recently changed because they are no longer working or are unpaid leave, the same documentation (tax return, etc.) is required. In addition the following documentation is required:

  - ✓ A statement of change indicating how the household income has changed
  - ✓ Documentation of the stated change – examples include:

    - employee termination letter
    - final check stub indicating termination date

PROGRAM ELIGIBILITY CRITERIA:

To qualify for a program, patients must meet certain eligibility criteria. The criteria varies by program.

**Prescription medication assistance*:

- ✓ US Citizen or permanent resident
- ✓ Meet financial criteria based on household size and income
- ✓ Diagnosed with cancer
- ✓ Has, or is in the process of securing private, independent, Cobra, or government health insurance. (If you do not have insurance you must provide documentation explaining why.)

Prescription medication assistance is provided on a month to month basis, beginning on the 1st day of the month through the end of the month. The patient or social worker will need to provide copies of prescriptions to CAGNO before going to assigned pharmacy.

Approvals are done Monday through Friday, 9am – 4pm only.

WE DO NOT PROVIDE APPROVALS ON WEEKENDS OR HOLIDAYS.

**CAGNO, under its discretion, may or may not pay for the medication requested.*

There will be no "rollover" of funds from month to month.

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**Financial Assistance – if funding is available*

- ✓ US Citizen or permanent resident
- ✓ Meet financial criteria based on household size and income
- ✓ Diagnosed with cancer
- ✓ Has, or is in the process of securing private, independent, Cobra, or government health insurance. (If you do not have insurance you must provide documentation explaining why.)

If financial assistance is available, you will be required to provide copies of invoices and/or bills for which you are requesting assistance. If approved, all checks will be made payable to the provider of service listed on the invoice or bill.

This information will be kept confidential and will not be shared with any third party.
We require this information to be updated on an annual basis.

SUSAN G. KOMEN LOUISIANA GRANT

Breast Cancer Patients only in the Susan G. Komen Louisiana Funding Area

Cancer Association of Greater New Orleans

824 Elmwood Park Boulevard; Suite 154, New Orleans, LA 70123-3347
Within Metro New Orleans (504) 733-5539 Outside Metro New Orleans 1-800-624-2039
Fax (504) 733-0252 www.cagno.org

PATIENT SERVICES ELIGIBILITY FORM FOR THE PERIOD OF July 1, 2019 – June 30, 2020

UPON COMPLETION, YOU CAN MAIL THE APPLICATION TO THE ADDRESS ABOVE OR SEND VIA FAX

Patient Information

Today's Date_____

Name_____Date of Birth:_____

Street Address_____Apartment_____

City _____, LOUISIANA Zip _____ Parish _____

Mailing Address_____

Telephone Number _____SSN#_____

RACE _____ SEX _____ Email address, if applicable

_____

Financial Information

TOTAL HOUSEHOLD INCOME per Month (please include patient, spouse and minor child) $_____ Household Income

Salary: $_____ Social Security $_____

Disability $_____ Other $_____

Employment Status: Employed_____ Unemployed_____ Retired_____ Disabled_____

Marital Status: Single_____ Children _____ if so, # of children under the age of 26yrs. still living in household _____

Couple____ Children _____ if so, # of children under the age of 26yrs. still living in household _____

Do you currently use tobacco in any form? ___ YES ___ EX-TOBACCO USER ___ NEVER USED TOBACCO

Would you like information on quitting tobacco use? _____Yes _____No

****Healthcare Insurance Information** *(select all that apply)*

~~*I do not have healthcare insurance _____~~ If you do not have insurance, you must provide documentation explaining why. Explanation of no insurance coverage-

_____

_____

_____

***If you have applied to Medicaid/Medicare and it is pending, you must submit documentation; once coverage has been approved, you must provide a copy of the approval to CAGNO.*

**If you have been denied coverage through Medicaid, Medicare or the affordable healthcare you must submit a copy of the denial to CAGNO.*

**If there are any significant changes in your financial status throughout the year, you are expected to promptly notify CAGNO.*

**If you are currently uninsured but obtain insurance at a later date, you are <u>required</u> to notify CAGNO and your assigned pharmacy immediately. This will not disqualify you from services provided by CAGNO but will allow CAGNO to help others in need.*

PLEASE NOTE:

Failure to comply with any of the above will result in you being disqualified from the patient services program. IF YOU HAVE INSURANCE AND YOU DO NOT PROVIDE INSURANCE INFORMATION TO CAGNO AND THE PHARMACY ASSIGNED TO YOU BY CAGNO, YOU WILL BE DISQUALIFIED FROM THE PROGRAM.

Private/HMO insurance

Insurance Co: _____

Policy ID #: _____

Group ID #: _____

Phone #: _____

Medicare Insurance/Medicaid Insurance

Medicare Policy #: _____

Plan Name: _____

Medicaid Policy #: _____

Part D Policy #

Other (example VA)

Insurance Co: _____

Policy ID #: _____

Plan Name: _____

Are you enrolled in a Medicare prescription plan? ___Yes ___No

My application is pending ___Yes ___N

Are you enrolled in a Medicare prescription drug plan? ___Yes ___Nov

Does the policy cover prescription drugs? Yes No Unsure

PATIENT REQUEST ASSISTANCE WITH THE FOLLOWING: Submit documentation such as # of appointments and miles traveled for transportation, Prescriptions or co-pays please include costs if known. If funding permits for Medical co-pays or Utilities and if you are requesting this assistance please included a copy of the bill.

Requested need	what to include	item
Prescriptions – those only related to Cancer Treatment	Include cost and pharmacy if known	
DME supplies	Such as Bed pads, diapers or nutrition	
If funding permits Utility's, Gas/food cards Medical Co-pays	Include copy of the Bill How # trips and Est mileage	
Other		

By signing this form, I understand that the Cancer Association can provide only the generic equivalents (unless no generic equivalent is available from any of the pharmaceutical companies) and I hereby authorize the use of generic equivalents to be substituted for medications that are prescribed for the above-named patient and paid for by the Cancer Association. I also authorize the Cancer Association of Greater New Orleans to obtain needed information to determine my eligibility for requested assistance.

*By signing, the referring professional verifies that the patient is currently in treatment for cancer. Chemotherapy, radiation, hormonal therapy or surgery If patient is no longer in active treatment. By signing this you are confirming the patient is in active treatment. *All information in this section is required and must be completed by treating Oncologist.*

1. **Treating Oncologist - _____**

2. **SIGNATURE** ** **of Treating Oncologist (required) _____**

CURRENT TREATMENT FACILITY: _____SECTION/DEPARTMENT _____

ADDRESS_____ _____

DEPARTMENT'S TELEPHONE NUMBER(S) _____DEPARTMENT'S FAX _____

Diagnosis – Patient WAS DIAGNOSED WITH Stage 0 1 2 3 4 CANCER type _____

ON ____/_____/_____ WITH Mets to _____

_____ _____ _____

SIGNATURE of Referring Professional & Title **(required)** Referring Professional's Telephone #, Ext and Fax number

_____ _____

PRINTED NAME of Referring Professional Referring Professional's Email Address

_____

SIGNATURE of Patient **(required)** If not the patient, name and relationship to patient of person supplying the information.