

Avila's Cancer Fund

Nonprofit Organization

PO Box 5956, Fresno, CA 93755 | info@avilascancerfund.org | 559-374-8613

Financial Assistance Application

Applicant Information

Full Name: _____

Date: _____

Address: _____

Apt/Unit: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

Annual Income: _____

Amount Requested: \$ _____

Intended use of financial assistance: _____

Do you have health insurance?

☐ Yes ☐ No

Do you travel for treatment?

☐ Yes ☐ No

Do you have a 48-hour notice?

☐ Yes ☐ No

If yes, where?

Have you been served an eviction notice? ☐ Yes ☐ No

If yes, explain: _____

Required Documents Checklist

☐ Copy of valid California ID, driver's license, or other acceptable verification of identity

☐ Patient signature

☐ Social worker, care coordinator, or physician's office verification/signature

☐ Proof of income from within the last three months

☐ Copy of the bill/invoice for the requested financial assistance

Important: Financial assistance is limited to amounts under \$500. Please do not request more than \$500.

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Financial Assistance Guidelines

Se Habla Español

- 1. Current treatment is required.** The patient must currently be receiving cancer treatment. The application must be verified and signed by a social worker, care coordinator, or physician's office. Examples of current treatment include chemotherapy, radiation, or a combination of both.
- 2. Patient signature is required.** Applications must be signed by the patient. Completed forms may be emailed. If you wish to come to the office, please contact Avila's Cancer Fund for an appointment.
- 3. Proof of identity is required.** Submit a valid California ID, driver's license, or other acceptable verification of identity. For questions, call 559-374-8613.
- 4. Payments are made directly to the vendor.** Payments may be made to PG&E, utility providers, landlords, mortgage companies, medical facilities, or physician offices for eligible co-pays. A copy of the bill must be submitted before payment. Lodging requests generally require the treatment facility to be at least 40 miles away and are reviewed case by case.
- 5. Avila's Cancer Fund provides limited financial assistance and food cards while funds are available.**
- 6. Patients may apply for financial assistance once every six months,** measured from the date of the first application.
- 7. Please allow 5-10 days after the completed application is received** to be notified of the decision.
- 8. Questions about our services may be emailed to info@avilascancerfund.org.**
- 9. Any approved financial assistance will be under \$500.** Please do not request an amount over \$500.
- 10. Proof of income is required.** Submit proof of income from within the last three months. If your income has changed during that period, include a written explanation.
- 11. Assistance is not available after treatment has ended.** Because funding is limited, Avila's Cancer Fund cannot provide financial assistance to patients who have completed treatment. This requirement is consistent with Guideline 1.
- 12. If you have completed treatment and have been released to return to work, Avila's Cancer Fund may provide return-to-work tips and resource information.**
- 13. Applicants of all ages are accepted, from newborns through adults.** We work with hospitals and oncology offices throughout California. To qualify for financial assistance, the patient must reside in California's Central Valley.
- 14. Before submitting your application, make sure it is complete.** Include proof of identity, the patient's signature, verification/signature from a social worker, care coordinator, or physician's office, proof of income, and a copy of the bill for the requested assistance.

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Patient Verification

This section must be completed and signed by a social worker, care coordinator, or physician's office.

Facility/Office: _____

Facility Phone: _____

Address: _____

Direct Number: _____

Name & Title: _____

Email: _____

Patient Name: _____

Patient DOB: _____

Physician Name: _____

Date: _____

Is the patient currently receiving cancer treatment? ☐ Yes ☐ No

Current treatment type: ☐ Chemotherapy ☐ Radiation ☐ Combination ☐ Other: _____

Does the patient travel more than 40 miles for treatment and appointments? ☐ Yes ☐ No

Certification and Signatures

I certify that the information provided in this application is true and complete to the best of my knowledge. By signing below, the patient attests to the accuracy of the information provided. A complete application must include the required verification and identification documents.

Social Worker / Care Coordinator / Physician Office Signature:

Date: _____

Patient Signature:

Date: _____

Submit completed applications and required documents to:

Avila's Cancer Fund, PO Box 5956, Fresno, CA 93755

Email: info@avilascancerfund.org | Phone: 559-374-8613