ANGELS SURVIVING CANCER, INC.
C. A. R. E -Cancer Awareness Resource Encouragement

I. C.A.R.E PROGRAM PURPOSE

The Angel's Surviving Cancer (ASC) C.A.R.E. Program provides support to individuals coping with the care and aftermath of Breast Cancer. ASC's primary focus is to helps patients and families with critical financial needs brought about by their treatment. Patient must demonstrate need as verified by the application.

ASC desire is to assist every patient that contacts our office, however there are specific requirements that must be met. Approved eligible patients can only receive a maximum of $400 financial assistance within a twelve (12) month period, based on the grant fiscal year. Patients must also understand that services are provided on an as needed and first come first serve basis. ASC cannot hold funds for patient's future use. Funds are not guaranteed to be available at the time of need.

II. ELIGIBILE EXPENSES UNDER C.A.R.E.

ASC's C.A.R.E. Program supports the following needs:

- Breast cancer medical co-payments
- Prescriptions related to breast cancer medical care
- Utility assistance to patients undergoing treatment
- Mortgage/Rental assistance to patients undergoing treatment
- Gas cards for patients undergoing treatment to get to and from treatments
- Metro cash cards for patients undergoing treatment, to get to and from treatments
- Groceries to support underage children of parent(s)/patient(s) undergoing treatment

III. HOW DOES C.A.R.E PROGRAM HELP?

ASC C.A.R.E. Program provides support services not to exceed $400 within a twelve (12) month period, within the grant period*. (*varies based on availability of funds)

ASC C.A.R.E. Program provides direct financial assistance to qualified patients for the payment of bills such as: mortgages payments, rent payments, utility payments, doctor visit co-pays, and prescription co-payments (for cancer drugs only). The **ASC C.A.R.E. Program** will make direct payments to the recipient's service providers. No funds are directed to the recipient themselves.
You do NOT qualify if your utility bills are currently being paid through a local low income Home Energy Assistance Program and/or other social service agency.

IV. INELIGIBLE EXPENSES

The **ASC C.A.R.E. Program** does not make payments for any medical treatments, insurance deductibles, car payments, car insurances, cable television, internet services, nor cell phones.

V. SUPPORT DOCUMENTENTATION REQUIRED

Clients that receive services from **ASC C.A.R.E. Program** are required to provide a copy of their Texas issued Identification Card or Driver's License, Passport, Social Security Card, and proof of residency. Proof of residency can be in the form of Lease Agreement, Mortgage statement, or utility bill with the same address as state issued identification.

The following documentation is needed to receive services:

- **Medical Co-payments** require a statement from the patient's insurance company or the Doctors office that details the due co-payment. **ASC C.A.R.E. Program** will pay at a maximum $50 co-payment.
- **Prescription assistance** is provided on a reimbursable basis. A patient is required to submit the receipt for cancer drugs only to the **ASC C.A.R.E. Program** for reimbursement. On a case by case bases a client may request an advance for Prescription assistance. Advance payment for prescription drugs can only be approved by the Executive Director of Angel's Surviving Cancer.
- **Utility assistance** can only be provided with a proof of delinquent payment and/or disconnection notice. The utility services must be for the residence in which the patient resides.
- **Mortgage assistance** can only be provided with statement from Mortgage Company that shows mortgage is 30 days delinquent.
- **Rental assistance** will be provided with eviction notice or proof that rental payment is 10 days delinquent and subject to eviction.
- All clients are eligible for **grocery assistance**, if requested. Grocery assistance will not exceed $250 within a twelve (12) month period. Clients will be issued gift cards and required to submit receipt of purchases within ten (10) days of distribution. Failure to submit receipts will result in ineligibility of future services.
- All clients are eligible for **Gas Cards/Metro Cash Card**. Cards will be distributed on an as needed bases, if requested by patient.

VI. HOW TO APPLY FOR SERVICES

All clients must submit an application to determine eligibility. Please note that it's important to make sure that you fill out each and every part of this application. Applications that are not complete will not be processed.

The Application process is brief and concise. In order to continue to serve cancer patients we ask that you please make sure everything is filled out, all copies requested are enclosed, and you send in a picture ID (legible copy).

VII. CONTACT INFORMATION

A client can submit an application via email or on our website at www.angelssurvivingcancer.net however all support documentation must be received prior to approval of services.

CARE APPLICATION

PERSONAL INFORMATION (PRINT CLEARLY) PLEASE BE SPECIFIC US ANOTHER PAPER IF NEEDED		
Are you a member of Angels Surviving Cancer, Inc.? ☐ Yes ☐ No		If **YES**, when did you join?
First Name:		Last Name:
Date of birth (M/D/Y):	Phone:	Email:
Current address:		
City:	State:	ZIP Code:

ASSISTANCE REQUESTED (CIRCLE ONE)		
Have you received CARE in the last 12 months? ☐ Yes ☐ No		
Office Visit Copay	Medical Related Lodging	Treatment Copay
Mammogram	Other (please describe)	

TREATMENT INFORMATION	
Stage of Breast Cancer:	Age at Diagnosis:
Treatment:	
Are you currently in treatment? ☐ Yes ☐ No	If **YES**, Treatment dates: Start:_____ Finish:_____
If **YES**, type of treatment:	

FINANCIAL STATUS		
Are you currently employed? ☐ Yes ☐ No	If **NO**, state reason:	
List sources of income:		
Amount of Request: $	Head of Household □ Yes ☐ No	Number in Household:
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K		
Explain circumstances creating financial need at this time:		
Is this a request for a bra or prosthesis only?		
What Size Bra do you wear?		**Do you have a physician prescription for bra or prosthesis?**
Is this a request for a Thanksgiving or Christmas food Basket from Angels which include Turkey and nonperishable food? Yes, or no		
Is this for Christmas clothes for children? yes no what size and ages		
Is this a request for boy or girl toys for Christmas? What Ages?		

HOW DID YOU HEAR ABOUT ANGELS SURVIVING CANCER, INC		
Referred by:		
Did referring Organization give you any assistance? ☐ Yes ☐ No		
Contact Name	Contact Email	Contact Phone

Angles C A R E RESOURCE ENCOURGEMENT

Office Use Only:

Verification Date: _____ Scan Date: _____