Benedictine Health Foundation's

Rosemary D. Gruner Memorial Cancer Fund

A helping hand for cancer patients and their families

Fund Application Form

Benedictine
HEALTH FOUNDATION

www.benedictinehealthfoundation.org

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Rosemary D. Gruner
Memorial Cancer Fund
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HEALTH FOUNDATION
Supporting the Benedictine Spirit of Compassionate Care

Mission Statement

Benedictine Health Foundation's ***Rosemary D. Gruner Memorial Cancer Fund*** ("the Fund") strives to aid in the treatment, care, and support of cancer patients in need.

The Fund provides assistance to cancer patients in the form of **grocery and/or fuel gift cards** (no cash funding is available).

Patients who are **actively receiving** cancer treatment and meet the following qualifications are eligible to apply:

1) Residents of Ulster County (regardless of the facility or location they currently receive cancer treatment), and residents of neighboring Mid-Hudson Valley Counties (receiving cancer treatment from a facility within Ulster County).
2) Annual household income of less than $55,000 (family) or $35,000 (single). Each patient will be required to provide income documentation upon submission of the application.

For assistance with cancer treatment products such as Prosthesis, Lymph Edema Sleeves, Wigs, Turbans, Surgical Bras and Compression Stockings that health insurance will not cover, please contact HealthAlliance of the Hudson Valley's Oncology Support Program located at 80 Mary's Avenue in Kingston, (845) 339-2071.

Review Process

1. Applications and income documentation will be received and reviewed by the Benedictine Health Foundation's staff. The Staff have received training for and are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. An applicant's information is considered confidential and is kept secured in keeping with HIPAA guidelines.

2. Upon meeting the clinical and financial qualifications, patients will be eligible to receive up to $800 in a calendar year in gift cards for fuel and/or groceries. Grocery assistance will be provided through Hannaford Gift Cards and fuel assistance will be provided through Stewart's Gift Cards.

   The Health Foundation office will notify the applicant within 14 days after receiving their form with the status of the application.

3. Maximum annual amount of $800 may be awarded each year for up to three years if the patient is actively receiving treatment and eligibility guidelines are met. Qualified applicants who have received assistance are eligible to reapply annually on the anniversary date of their last received award. After three years, assistance may be applied for if the applicant is in treatment due to a recurrence or due to a new diagnosis, or if permanently disabled from their cancer diagnosis. Patient assistance after three years will be awarded at the discretion of the Foundation.

Questions about the Gruner Fund Application or the status of an application should be directed to the Benedictine Health Foundation office at 845-481-1303.

For questions about HealthAlliance's Oncology Support Program and Services, call 845-339-2071.

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#_____

PATIENT ASSISTANCE PROGRAM APPLICATION

Revised 4/30/2024

Section 1 TO BE COMPLETED BY PATIENT- PLEASE PRINT ☐ female ☐ male

_____

(Patient name) First Middle Initial Last

_____

Mailing address: Street / PO Box / Apartment # City State Zip Code

PATIENT TEL. #: ( ) _____ PATIENT SS # (last 4 digits only) _____ DOB: _____
Month / Day / Year

PATIENT EMAIL: _____ REFERRED BY: _____

If applicable, NAME OF PATIENT'S ADVOCATE (authorized to act on behalf of Patient):
_____ TEL #: ( ) _____

Optional: ____American Indian/Alaskan Native _____ Asian ____ Black/African American ____ Hispanic/Latino

____Native Hawaiian/Pacific Islander _____White

HAVE YOU RECEIVED GRUNER FUND ASSISTANCE IN THE PAST? ☐ YES ☐ NO
IF "YES", APPROXIMATELY WHEN DID YOU LAST RECEIVE ASSISTANCE? (Date): Month_____ Year_____

Qualifying for Assistance - Patients in treatment with an **annual income** of: ☐ FAMILY ($55,000 or less) ☐ Single ($35,000 or less)

ANNUAL GROSS HOUSEHOLD INCOME (From Previous Year): $_____

CURRENT YEAR'S PROJECTED GROSS HOUSEHOLD INCOME: $_____

Income verification for <u>all household members</u> must be attached or the application will not be considered and returned. Check below the type of income verification that is being submitted with this application.

☐ Most recent W-2 (one month) ☐ Copy of Medicaid Card ☐ Other (please print):_____

☐ Most recently filed Federal Income Tax Return for household or other type of income verification from State or Federal agency

My signature below attests that the information provided for this application is complete and accurate. Additionally, I understand that I may be required to provide further information and documentation at the request of the Benedictine Health Foundation staff for the purpose of determining my eligibility to participate in this Patient Assistance Program ("Program"). I agree to inform Benedictine Health Foundation of any change or circumstance that may impact my eligibility in this Program. Any untruthful or fraudulent information provided, or my refusal to cooperate with the requirements of this Fund, may be grounds for denial of assistance. I understand that the Fund may engage a third party to assist with the services of this Program, and I agree for the Fund to release to the necessary third party any information I supply in connection with this application that is required for such administration. Except to the consent required by law or for the purpose of administering this Patient Assistance Program, I understand that the information provided will be kept confidential.

_____ _____
Patient's Signature ***Date***

If Patient is 18 years of age or under, Legal Guardian (print name): _____

_____ _____
Legal Guardian's Signature **Date**

TOTAL MAXIMUM ANNUAL AMOUNT is $800 * PLEASE INDICATE BELOW ASSISTANCE NEEDED

☐ GIFT CARDS FROM **HANNAFORD SUPERMARKETS**: Amount requested ($50 increment): $_____

☐ GIFT CARDS FROM **STEWART'S SHOPS (GAS ONLY)**: Amount requested ($50 increment): $_____

Arrangements can be made to return any unused cards to the Foundation so that other cancer patients can benefit from the program.

☐ I, or my designee (print full name) _____, will **PICK UP** gift cards. Date, time and place will be discussed at time of acceptance call Monday – Friday, 8AM to 4PM

** Maximum annual amount may be awarded each year for up to three years if still in treatment and eligibility guidelines are met. Applicant who has received assistance is eligible to reapply on the annual anniversary date of their last award. After three years of assistance, the patient may apply again for assistance only in cases of permanent disability or treatment due to recurrence; and if awarded, will be at the discretion of the Benedictine Health Foundation.*

SECTION 2

This section must BE COMPLETED IN FULL by the HEALTHCARE PROVIDER CURRENTLY OVERSEEING PATIENT'S CANCER TREATMENT or the application will be returned.

PLEASE PRINT CLEARLY:

PATIENT'S NAME: _____
FIRST MIDDLE INITIAL LAST

PHYSICIAN'S NAME: _____PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

TELEPHONE NUMBER: ( ) _____ FAX NUMBER: ( ) _____

(If Applicable) NAME of PHYSICIAN'S REPRESENTATIVE COMPLETING APPLICATION: _____

TYPE OF CANCER THAT PATIENT IS CURRENTLY IN TREATMENT FOR (check all that apply):

☐ Breast ☐ GYN / Ovarian ☐ Colon
☐ Brain ☐ Lung ☐ Leukemia
☐ Esophageal ☐ Head / Neck ☐ Prostate ☐ Other Cancer Diagnosis: _____

IS THE PATIENT CURRENTLY RECEIVING TREATMENT: ☐ YES ☐ NO (check): ☐ Chemotherapy ☐ Radiation ☐ Endocrine Therapy

☐ **Other – Please provide specific details of cancer-related treatment below. Applications will not be processed without this information**.

_____
_____
_____
_____

IS THE PATIENT CURRENTLY in the Hospital ☐ YES ☐ NO

NAME OF FACILITY PATIENT IS CURRENTLY RECEIVING TREATMENT: _____

ADDRESS OF FACILITY: _____

Print Name of Physician / Representative: _____

Signature of Physician / Representative: _____ Date: _____

Application Submitted to Benedictine Health Foundation by (PLEASE PRINT):

NAME_____Phone:_____Date:_____

NOTE: Incomplete applications will be returned to the patient or their representative for re-submission with ALL required information.

APPLICANT "OPT OUT" NOTICE: Designated staff from the HealthAlliance Oncology Support Program may follow-up with Rosemary D. Gruner Memorial Cancer Fund applicants as a courtesy to offer support and to provide additional information about the cancer care programs and services they offer. If you **do not want to be contacted** for this purpose OR if you **do not wish to receive** future communications/mailings from the HealthAlliance Oncology Support Program or the Benedictine Health Foundation's Rosemary D. Gruner Memorial Cancer Fund, please sign and date below:

Applicant (or legal guardian) Signature: _____ *Date:* _____

Return completed and signed application form, with all required verification documents to:

BENEDICTINE HEALTH FOUNDATION, INC.
Rosemary D. Gruner Memorial Cancer Fund
144 Pine Street, Ste. 220, Kingston, New York 12401 or fax application to: 845-663-2221
www.benedictinehealthfoundation.org / (845) 481-1303