**Financial Assistance Guidelines**

**Purpose**

The goal of this program is to financially assist patients and their families who reside in Interior Alaska, in dealing with financial challenges faced when undergoing cancer treatment. Assistance may include (but is not limited to) travel expenses to treatment locations, local transportation, housing/utilities, non-covered prescriptions, childcare, groceries, and gas.

**Application Process**

A financial assistance application must be completed and submitted to IACA. Applications can be obtained by calling IACA at 374-0974 or through your health care provider. The application must clearly state the type and amount of financial assistance requested. The IACA will review each application and a decision will be made as soon as possible.

**Qualifications**

To qualify, the applicant must submit a completed application and meet all the following criteria:

1. The applicant must be a resident of Interior Alaska, as defined by the IACA Board of Directors, and must reside in Interior Alaska for greater than 6 months out of the year.
2. The applicant must not have the same or comparable financial assistance (or in-kind services) available to him/her though any other federal or state agency or any medical insurance, or other program.
3. The applicant must secure a signed statement from their physician verifying they are currently being treated for cancer, and attach it to the application. For our purposes the IACA defines a physician as an MD or a DO licensed to practice medicine in the State of Alaska.

**Payment**

Successful applicants will not receive cash payments. Bills and other requests are paid directly to the vendor by IACA.

**Limitations**

The IACA reserves the right to place limits on financial assistance so that others may fully benefit from the program.

**Financial Assistance Application**

**Contact & Residence**

Date \_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

Phone (primary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (secondary)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of time residing in Interior Alaska \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician Verification**

Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s verification attached? (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Request**

Please describe the purpose of requested funds.

Amount requested: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Certification**

By providing my signature below, I authorize the IACA Board of Directors to contact my physician to verify that I am currently undergoing cancer treatment. I certify that I have resided in Interior Alaska for at least 6 months. I certify that I do not have the services for which I am requesting financial assistance available through any federal or state agency, medical insurance, or assistance program. I understand that all decisions of IACA are final and assistance is determined based on qualification, verification, and availability of funds.

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Signature Date

This box for IACA use only:

Date received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date reviewed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician verification attached?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Action taken & Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant contacted Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_