Chenango Health Network (CHN)
Financial Assistance Program Application
For Patients with Non-Breast Related Cancer
MUST BE CHENANGO COUNTY RESIDENT

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ New York Zip: _____

Home Phone number: _____ Cell Phone Number: _____

Email Address: _____

Are you currently being treated? ___ No (if no-not eligible for assistance) ___ Yes, if so what treatments: _____

_____

Medical Provider Attestation that Applicant is a Cancer Patient

_____	_____	_____
Date of Cancer Diagnosis	Type of Cancer	Stage of Cancer
_____	_____	_____
Print Provider Name	Provider Signature	Date

_____
Hospital/Medical Center Name & Address

Assistance Requested (check all that apply) ___Gas Cards ___Medical Bills ___Prescriptions ___Medical Supplies ___Other

Please describe your need: _____

_____

Amount of Financial request: $_____

I give permission to Chenango Health Network to speak with this friend/family member about my request:

Name: _____ Phone: _____

General Information: ___ yes - I have medical Insurance (Please complete below) ___ No - I do not have medical Insurance

Insurance Provider(s): _____ Group/Policy Number:_____

Annual Deductible amount: $_____

Are you currently working: ____ FT ____ PT Employer: _____

Have you lost time from work due to your cancer diagnosis? _____

Have you received assistance from Chenango Health Network in the past? ____No ____Yes

If Yes, When? _____ How much? $_____

CHN does not release personal information to anyone except to gain assistance in providing you with the help you seek. Please sign this form, indicating that CHN has your permission to share or obtain personal, confidential information to organizations and/or individuals who may assist in providing that help or may require accounting or monitoring information.

Applicant Signature: _____ Date: _____

You must be a resident of Chenango County to be eligible for the Financial Assistance Program. Please provide a copy of the invoices or bills to be paid. Please note that all expenses are paid directly to the provider vendor, and we cannot reimburse the patient for any bills already paid. *Only one application may be submitted within six (6) months. You may reapply for assistance if you have a recurrence/special circumstances.*

Please note that the Financial Assistance Program priorities are as follows in order of importance

- Medical bills not paid by insurance
- Co-pays
- Prescription drugs (related to cancer diagnosis)
- Medical supplies
- Gas and transportation for medical appointments

Chenango Health Network cannot pay for:

- Living expenses – rent, utilities, cable bills, water bills, etc.
- Auto insurance or auto repair bills
- Tax bills of any kind

If you need assistance with this application, please contact our office at 607-337-4128. Please return your completed application to:

Chenango Health Network
19 Eaton Avenue
Norwich, NY 13815
Fax: 607-337-4276

This program is funded through donations - assistance is dependent upon availability of funding.