Access to Care: Patient Emergency Fund

As the novel coronavirus (COVID-19) continues to affect the world at-large, Lung Cancer Initiative feels the urgency of carrying out our mission now more than ever. Lung cancer survivors are a particularly high-risk group for this virus and we are committed to continuing to provide support to the lung cancer community through the duration of this pandemic.

The Access Grant Program allows LCI to address other barriers to lung cancer care beyond transportation. LCI awards up to three access grants with each grant providing up to $10,000 to assist community organizations, medical institutions or other partners in enhancing access to lung cancer screening, treatment, clinical trials, comprehensive biomarker testing or precision medicine for uninsured or underinsured individuals.

In 2020, Lung Cancer Initiative has allocated one $10,000 access grant to create the Patient Emergency Fund. This fund is designed to support lung cancer patients and their families who have been financially impacted by the coronavirus pandemic. Through the Patient Emergency Fund, LCI hopes to help lung cancer patients stay healthy and to meet their basic needs throughout the COVID-19 pandemic.

LCI realizes that this is a critical time for lung cancer patients, when barriers to treatment are larger than ever. Through the Patient Emergency Fund, lung cancer patients will be able to apply for a stipend of $250 to help with healthy food costs, transportation and other non-medical expenses. Patients will complete a 2-page application that includes a signature from their healthcare provider. The healthcare provider signature ensures the patient is a lung cancer survivor actively receiving treatment.
Access to Care: Patient Emergency Fund

In response to the coronavirus pandemic, Lung Cancer Initiative of North Carolina is offering the Patient Emergency Fund to provide financial support for lung cancer patients to help with healthy food costs, transportation and other non-medical expenses during this time.

Dear Applicant:
Below are the guidelines to assist you with the completion of the paperwork necessary to apply for the patient emergency fund.

Applications may be sent to:
Mail: Colleen Christensen
5171 Glenwood Ave, Suite 401
Raleigh, NC 27612
Email: cchristensen@lungcancerinitiativenc.org
Fax: 919-784-0416

Directions to Apply

1. All questions must be answered in order to be considered for fulfillment.
2. Applications must have a signature from the healthcare facility. The patient’s signature is optional, as we are aware many lung cancer patients are rescheduling in-person appointments and not able to physically sign.
3. Once we receive the application, please allow 2 weeks for the application to be processed.
4. After the application is processed and approved, a Visa gift card for $250 will be mailed to the patient’s address. Colleen will email the healthcare provider to notify when the check has been mailed.

Guidelines

1. Applicants must be a resident of North Carolina.
2. Applicants must currently be in treatment for lung cancer.
3. Lung Cancer Initiative has allotted $10,000 for this program. Once these funds have been depleted, the emergency funds will no longer be available. Please check with Colleen Christensen to check the status of the program.
4. A patient may only apply once for these funds.
5. If possible, please submit application by email. Due to our staff working remotely, mailed and faxed applications may not be received until up to a week after sending the application.
Access to Care: COVID-19 Patient Emergency Fund Application

Name of Applicant: ____________________________ Date: ________________

Address: ____________________________ Date of Birth: ______

Phone Number: ____________________________

Email address (required): ____________________________

All demographic information is collected for reporting purposes only. This information has no bearing on the approval of this application.

1.) Please, specify your ethnicity. (Please check)

□ Hispanic/Latino       □ Not Hispanic/Latino

2.) Please, specify your race. (Please circle all that apply)

<table>
<thead>
<tr>
<th>Native American</th>
<th>Native Hawaiian/Other Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td>Black or African American</td>
<td>Other: ____________________________</td>
</tr>
</tbody>
</table>

3.) What is your total household income each year? (Please circle)

<table>
<thead>
<tr>
<th>Less than $10,000</th>
<th>$10,000 to $19,999</th>
<th>$20,000 to $29,999</th>
<th>$30,000 to $39,999</th>
<th>$40,000 to $49,999</th>
<th>$50,000 to $75,000</th>
<th>$75,000 to $100,000</th>
<th>$100,000 or more</th>
</tr>
</thead>
</table>

(Please answer the following questions by checking the boxes with an X or √)

4.) Has your employment status changed due to the coronavirus?       □ Yes       □ No

   a.) If working, have you had to reduce hours?       □ Yes       □ No       □ N/A

   b.) If not currently working, did you have to take temporary leave or quit?       □ Yes       □ No       □ N/A
6.) Please describe your need for financial assistance at this time:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

7.) How did you find out about this emergency fund program? (Please circle)

<table>
<thead>
<tr>
<th>Cancer Treatment Center</th>
<th>Primary Care Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another Lung Cancer Patient</td>
<td>Friend or Family Member</td>
</tr>
<tr>
<td>Online</td>
<td>Other: _____________________</td>
</tr>
</tbody>
</table>

**Healthcare Facility Information**

Name of the facility where treatment will be received:______________________________________________

Address of facility:______________________________________________

Name of Physician:______________________________________________

Healthcare Facility Contact Person:______________________________________________

Email of Contact Person:______________________________________________

Phone Number of Contact Person:______________________________________________

Diagnosis:______________________________________________

Is the patient currently enrolled in a clinical trial? (please circle one)  Yes  No

Signature of Patient (optional):______________________________________________

Signature of Contact from Healthcare Facility:______________________________________________