5171 Glenwood Ave. Suite 401

Raleigh, NC 27612

(919) 784-0410

**Patient Emergency Fund**

In response to the COVID-19 pandemic and other emergencies associated with a lung cancer diagnosis, Lung Cancer Initiative (LCI) 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 uncertain times.

**Applications may be sent to:**

**Mail: Savannah Dodson**

 **5171 Glenwood Ave, Suite 401**

**Raleigh, NC 27612**

**Email: sdodson@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. One Healthcare Facility Contact may refer up to two patients in need.
4. Applications will be accepted until November 14th, 2022 and decisions will be communicated by shortly after. All mailed applications postmarked by November 14th, 2022 will be considered.
5. After the application is processed and approved, a check for $200 will be mailed to the patient’s address. Savannah 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. Please submit applications by email, mail, or fax, utilizing the contact information above.
4. LCI has budgeted to provide stipends to 50 patients across North Carolina. If more than 50 applications are received, priority will be given to patients living in the most distressed counties as indicated by NC Commerce’s County Distress Rankings and the patient’s demonstrated need.

**Patient Emergency Fund Application**

Applicant Full Name: Date:

Address: Date of Birth:

 County of Residence:

Home Phone Number:

Cell Phone Number:

Patient Email Address (Required):

□ Please check this box if you would like to opt-out from Lung Cancer Initiative emails.

1.) Please, specify your ethnicity.

|  |  |
| --- | --- |
| □ Hispanic/Latino | □ Not Hispanic/Latino |

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

|  |  |
| --- | --- |
| □ Native American  | □ Native Hawaiian/Other Pacific Islander |
| □ Asian | □ White/Caucasian |
| □ Black or African American | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |  |
| --- | --- | --- |
| □ Less than $10,000 | □ $30,000 to $39,999 | □ $75,000 to $100,000 |
| □ $10,000 to $19,999 | □ $40,000 to $49,999 | □ $100,000 or more |
| □ $20,000 to $29,999 | □ $50,000 to $75,000 |  |

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

|  |  |  |
| --- | --- | --- |
| 4.) Are you employed? | □ Yes | □ No |
|  a.) If yes, do you work part-time or full-time? | □ Yes | □ No | □ N/A |
|  b.) If no, are you on disability? | □ Yes | □ No | □ N/A |
|  c.) If no, are you retired?  | □ Yes | □ No | □ N/A |

6.) Please describe your need for financial assistance at this time:

7.) How will you utilize the funding proved through this program?

8.) How did you find out about this patient emergency fund program?

|  |  |
| --- | --- |
| □ Cancer Treatment Center | □ Primary Care Physician |
| □ Another Lung Cancer Patient | □ Friend or Family Member |
| □ Online | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**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? □ Yes □ No

**Signature of Patient (optional):**

**Signature of Contact from Healthcare Facility:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_