



**LUNG CANCER INITIATIVE**  
A NETWORK OF HOPE AND ACTION

5171 Glenwood Ave. Suite 401  
Raleigh, NC 27612  
(919) 784-0410

### **Patient Access to Care Gas Card Program**

The Lung Cancer Initiative offers the Patient Access to Care Gas Card Program to provide assistance to lung cancer patients while seeking treatment. The Initiative hopes this program will lessen the financial burden of patients receiving appropriate lung cancer treatment.

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Dear Applicant:

Below are the guidelines to assist you with the completion of the paperwork necessary to apply for a gas card.

**Applications may be sent to:**

**Mail: Savannah Dodson**

**5171 Glenwood Ave, Suite 401**

**Raleigh, NC 27612**

**Email: [sdodson@lungcancerinitiativenc.org](mailto:sdodson@lungcancerinitiativenc.org)**

**Fax: 919-784-0416**

1. **All questions must be answered** in order to be considered for fulfillment.
2. Applications must have the **patient's signature** and a **signature from the healthcare facility**.
3. Once we receive the application, please allow **2 weeks** for the application to be processed and mailed.
4. The gas card will be mailed to the patient's address.

### **Gas Card Guidelines**

1. Applicants must be a resident of North Carolina.
2. Applicants must currently be in treatment for lung cancer.
3. Applicants may apply once every four months to receive a \$50.00 gas card.
- 4. Each time an applicant applies, a new application must be filled out.**
5. For 2021, a limit of 125 gas cards will be allotted **every quarter**. If we run out for that period, your healthcare facility contact person will be notified.

# Lung Cancer Initiative Access to Care Gas Card Application

Name of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Already received a gas card: Yes/No

Phone Number: \_\_\_\_\_

If yes, how long ago: \_\_\_\_\_

Email address (required): \_\_\_\_\_

County: \_\_\_\_\_

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

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	

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

<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Not Hispanic/Latino
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3.) Please, specify your race. (Please circle all that apply)

Native American	Native Hawaiian/Other Pacific Islander
Asian	White/Caucasian
Black or African American	Other: _____

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

4.) Are you currently working while undergoing treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
a.) If working, have you had to reduce hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
b.) If not currently working, did you have to take temporary leave or quit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5.) Have you ever missed treatment due to transportation difficulties?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

6.) Please describe your need for travel assistance:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Lung Cancer Initiative Access to Care Gas Card Application

7.) How did you find out about the gas card program? (Please circle)

Cancer Treatment Center	Primary Care Physician
Another Lung Cancer Patient	Friend or Family Member
Online	Other: _____

8.) Which of the following gift cards would you prefer?

BP	Exxon Mobil
Uber (Rideshare)	

## 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: \_\_\_\_\_

## Treatment Information

Please estimate the number of miles roundtrip to treatment within the next **90 days** using the calculation below:

$$\frac{\text{_____}}{\text{(Miles roundtrip for 1 trip)}} \times \frac{\text{_____}}{\text{X (# of trips to treatment)}} = \frac{\text{_____}}{\text{= (Anticipated miles for 90 days)}}$$

Type of Treatment: \_\_\_\_\_

Duration of Treatment: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

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

**Signature of Patient:** \_\_\_\_\_

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