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.

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: Alisha Patel**

**5171 Glenwood Ave, Suite 401**

**Raleigh, NC 27612**

**Email: apatel@lungcancerinitiative.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.**

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)

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

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? | □ 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 |
| 5.) Have you ever missed treatment due to transportation difficulties? | □ Yes | | □ No | |

6.) Please describe your need for travel assistance:

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 round trip to treatment within the next **90 days** using the calculation below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ = \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Miles roundtrip for 1 trip) X (# of trips to treatment) = (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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_