LUNG CANCER INITIATIVE
A NETWORK OF HOPE AND ACTION

Patient Emergency Fund Application

Lung Cancer Initiative (LCI) offers 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.

Please enter the access code below to continue with the Patient Emergency Fund Application.
If you do not have the access code, please email Alisha Patel at apatel@lungcancerinitiative.org or call (919) 784-0410.
If you are a patient, please have your nurse navigator contact us for the access to code to fill out the application on your behalf.

Enter Access Code

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. One healthcare facility contact may refer up to 2 patients in need.
4. Once we receive applications, please allow up to **2 weeks** for the application to be processed and mailed.
5. After the application is processed and approved, a check for **$100 will be mailed to the patient's address.** LCI will email the healthcare provider to notify when the check has been mailed.

Patient Emergency Fund Guidelines

6. Applicants must be a resident of North Carolina.
7. Applicants must currently be in treatment for lung cancer.
8. Stipends are available until funds are depleted. 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.
9. Each applicant can receive **ONE STIPEND PER CALENDAR YEAR.**

Today's Date *

Month Day Year

Applicant's Full Name: *

First Name Last Name

Sex *

- Male
- Female

Date of Birth *

Month Day Year

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

County of Residence *

Name of County

Cell Phone Number *

Please enter a valid phone number.

Patient's Email Address *

example@example.com

Please, specify your ethnicity. *

- ○ Hispanic/Latino
- ○ Not Hispanic/Latino

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

- ☐ Native American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ White/Caucasian
- ☐ Black or African American
- ☐ Other

Are you employed? *

- ○ Yes
- ○ No

If yes, do you work part-time or full-time? *

- ○ Part-time
- ○ Full-time
- ○ N/A

If no, are you on disability? *

- ○ Yes
- ○ No
- ○ N/A

If no, are you retired? *

- ○ Yes
- ○ No
- ○ N/A

What is your total household income each year? *

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

Please describe your need for financial assistance at this time. *

How will you utilize the funding provided through this program? *

- ☐ Treatment expenses (including co-pays, medications, insurance, etc.)
- ☐ Travel and lodging
- ☐ Childcare
- ☐ Utilities and home expenses
- ☐ Food and groceries
- ☐ Other

Please further explain, if needed.

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: *

Name of Healthcare Facility

Address of Facility *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Name of Physician *

First Name | Last Name | Credentials

Name of Healthcare Facility Contact Person *

First Name | Last Name | Credentials

Email of Healthcare Facility Contact Person *

Phone Number of Healthcare Facility Contact Person *

Please enter a valid phone number.

Diagnosis of Patient *

Type(s) of Treatment Patient Will Receive *

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Immunotherapy
- ☐ Surgery
- ☐ Other

Is the patient currently enrolled in a clinical trial? *

- ○ Yes
- ○ No

Signature of Patient

Signature of Healthcare Facility Contact Person

For providers completing this application on behalf of a patient: Please mark the checkbox indicating that the patient has given their consent for you to sign there instead. *

- ☐ Yes, they have given their consent