LUNG CANCER INITIATIVE
A NETWORK OF HOPE AND ACTION

Tomma Hargraves Gas Card Program

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

Please enter the access code below to continue with Care Gas Card 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.

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. Once we receive applications, please allow up to 2 weeks for the application to be processed and mailed.
4. The gas card will be mailed to the patient's address. LCI will email the healthcare provider to notify when the gas card has been mailed.

Gas Card Guidelines

5. Applicants must be a resident of North Carolina.
6. Applicants must be currently in treatment for lung cancer.
7. Applicants may apply once every four months to receive a $50.00 gas card.
8. Each time an applicant applies, a new application must be filled out.

Today's Date *

Day Year

Is this a returning application? *

- Yes
- No

Have you already received a gas card? *

- Yes
- No

If yes, how long ago? *

Applicant's Full Name *

First Name Last Name

Date of Birth *

Month Day Year

Sex *

- Male
- Female

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

County of Residence *

Phone Number *

Please enter a valid phone number.

Email *

example@example.com

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
- ☐ Other

Please specify your ethnicity. *

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Please specify your race. *

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

Are you currently working while undergoing treatment? *

- ○ Yes
- ○ No

If yes, have you had to reduce hours? *

- ○ Yes
- ○ No
- ○ N/A

If no, did you have to take temporary leave or quit? *

- ○ Yes
- ○ No
- ○ N/A

Have you ever missed treatment due to transportation difficulties? *

- ○ Yes
- ○ No

Please describe your need for travel assistance. *

How did you hear about the gas card program? *

- ☐ Cancer Treatment Center
- ☐ Primary Care Physician
- ☐ Another Lung Cancer Patient
- ☐ Friend or Family Member
- ☐ Online
- ☐ Other

What type of card is more beneficial for you? *

- ○ Gas Card
- ○ Rideshare

Which of the following gift cards would you prefer? *

- ○ BP
- ○ Exxon Mobil
- ○ Uber (Rideshare)
- ○ No Preference (BP or Exxon Mobil)

Healthcare Facility Information

Name of Facility Where Treatment will be Received *

Name of Healthcare Facility

Address of Facility *

City State / Province

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 *

example@example.com

Phone Number of Healthcare Facility Contact Person *

Please enter a valid phone number.

Please estimate the number of miles roundtrip to treatment within the next 90 days using the calculation (miles per roundtrip x number of treatment = anticipated miles for 90 days) *

Treatment Information

Diagnosis of Patient *

Type(s) of Treatment Patient Will Receive *

- [ ] Chemotherapy
- [ ] Radiation
- [ ] Immunotherapy
- [ ] Surgery
- [ ] Targeted therapy
- [ ] Other

Is the patient currently enrolled in any clinical trials? *

- ( ) Yes
- ( ) No

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

Signature of Patient