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.**

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.

Today's Date *

Month Day Year

Sex *

Male
Female

Applicant's Full Name: *

First Name Last Name

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

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

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. *

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 *

example@example.com

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

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

____

Signature of Healthcare Facility Contact Person

____