OVERVIEW OF FINANCIAL ASSISTANCE

(Keep this page for your records)

TOUCH INC. (TOUCH) provides non-medical financial assistance for a cancer patient if the applicant meets our criteria explained below under "Who We Can Help". TOUCH does not pay medical expenses, but we do help with everyday expenses such as transportation, utilities, childcare, housing such as mortgage or rent, and other out-of-pocket expenses that are non-medical but are unable to be paid by the patient as a result of the cancer diagnosis. We DO NOT pay credit card bills. Each application is given careful, individual consideration, but TOUCH does not guarantee assistance to anyone. All awards are made at the sole discretion of TOUCH.

TOUCH has limited financial resources and will not be able to meet all your financial needs while you are undergoing treatment. We strongly encourage you to explore all other options for assistance during your treatment.

WHO WE CAN HELP

SERVICE AREAS: The areas served by TOUCH are those residents of Vanderburgh and Warrick counties in the state of Indiana. A driver's license or a copy of an apartment lease or bill with your name and address to verify resident status may be required. Depending on available resources and specific cases, TOUCH may decide to broaden this service area as needed/able.

MEDICAL: Your need for financial assistance must be related to your cancer diagnosis and treatment. To qualify for assistance, you must have been diagnosed with cancer within the previous six months, or currently undergoing medical treatments for the cancer. Federal HIPPA regulations require that TOUCH obtain your permission in writing to discuss your case with anyone else. TOUCH will need diagnosis and treatment information from your medical provider and must have proof of your consent to obtain this information.

FINANCIAL:

1. **Income:** Your total household income from all sources including wages, government assistance and retirement funds (if you are already retired) at the time of application must be less that 300% of the current Federal Poverty Level Guidelines.

2. **Assets:** Your cash or liquid assets (i.e., CDs, stocks, mutual funds) must be less than your estimated expenses for the duration of treatment. TOUCH does not require you to get rid of your primary residence, vehicle, or personal items to qualify for assistance from us. We may, however, disqualify you from receiving assistance or reduce the amount of assistance we offer, if you have liquid assets that could be used to pay your expenses.

IMPORTANT NOTICE: TOUCH may verify any information submitted. If you provide incorrect or misleading information on your application, on additional materials, or in any verbal communication with TOUCH personnel, TOUCH reserves the right to immediately suspend any and all current and future funding and recover all such amounts.

HOW MUCH WE CAN HELP

The amount of support we provide for each individual may vary depending on need and TOUCH's resources. We have a fixed monthly limit of $250 up to a maximum of 12 months of assistance (months can be non-consecutive). This amount is not guaranteed and is based on the availability of funds. **Patients must call each month** in order to verify that they still have a need for assistance.

HOW WE CAN HELP

Checks will be paid directly to the vendor, not the cancer patient, and TOUCH may require a written statement or verification from the vendor of the amount due. The cancer patient should not have to pay any income tax on the help provided by TOUCH.

APPLICATION DIRECTIONS

(Keep this page for your records)

1. Use the following checklist to help you determine your eligibility

☐ YES ☐ NO I understand that TOUCH does not pay for medical expenses or credit card bills of any kind.

☐ YES ☐ NO I live in Vanderburgh or Warrick County.

☐ YES ☐ NO I am currently a cancer patient diagnosed within six months of today's date, or I am currently undergoing cancer treatments.

2. Complete the TOUCH Application

THE APPLICATION SHOULD BE FILLED OUT COMPLETELY AND ACCURATELY. An incomplete and/or inaccurate form will delay review of your application and could result in being declined for the program.

☐ I have signed the top of the **completed** Physician Form (filled out by your physician) and included with the application that serves as a medical release, allowing my doctor's office to share medical information needed to process my application with **TOUCH** and **Cancer Pathways Midwest (CPM)**. I agree to provide accurate information and understand that TOUCH and CPM work together on my behalf to provide cancer support and all information shared with them will be kept confidential.

☐ I understand that TOUCH will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or personal interview.

☐ I have signed the liability clause at the end of the personal information section in the application.

3. Gather your documents

THE FOLLOWING DOCUMENTS MUST BE RETURNED WITH YOUR APPLICATION:

1. **PROOF OF RESIDENCY:** You must provide proof of your physical address to verify the address provided on the application form. Acceptable documents include:
   - A copy of your Driver's License or other government issued ID showing the address listed on the application.
   - A copy of a bill, pay stub or bank statement showing the address listed on the application.
2. **MEDICAL STATUS VERIFICATION:** Submit the completed and signed Physician Form from your oncologist/physician verifying your current diagnosis and treatment plan.

4. Return you completed application and required documents to TOUCH

BY MAIL: TOUCH INC. c/o Cancer Pathways
5740 Vogel Rd
EVANSIVLLE, IN 47715

OR, BY EMAIL: CONTACT@TOUCHINDIANA.ORG

APPLICATION FOR FINANCIAL ASSISTANCE

Section 1: Personal Information

Full Name:					
Date of Birth:		Social Security Number:	– –		
Street Address (must match your ID):					
City:		State:		Zip:	
Home Phone:		Cell:		Work:	
Best phone number to reach you:	☐ Home ☐ Cell ☐ Work	Best time to call:			
Marital status:	☐ Single ☐ Married ☐ Divorced/Separated				

Additional Contact Information:

TOUCH INC. may discuss my application with the additional people below if we can't reach you directly.

1. Full Name:			
Phone:		Relationship:	☐ Spouse ☐ Parent ☐ Child ☐ Other
2. Full Name:			
Phone:		Relationship:	☐ Spouse ☐ Parent ☐ Child ☐ Other

Insurance Information:

Health Insurance:	☐ None ☐ Medicaid ☐ Medicare ☐ Private ☐ Other	Insurance Carrier:
Insurance provided through:	☐ My Employment ☐ Spouse's employment ☐ Other	

Employment Information:

Employment status **BEFORE** your cancer diagnosis:

☐ Full-time ☐ Part-time ☐ On Leave ☐ Self-employed ☐ Retired ☐ Unemployed

Employment status **AFTER** your cancer diagnosis:

☐ Full-time ☐ Part-time ☐ On Leave ☐ Self-employed ☐ Retired ☐ Unemployed

Place of Employment:		Date of last Employment:	

TOUCH INC. OFFICE USE ONLY – DO NOT WRITE IN THIS SECTION

Date Received:	Application Approved: ☐ Yes ☐ No	Date Approved:	Review Date 1:	Review Date 2:	Review Date 3:

APPLICATION FOR FINANCIAL ASSISTANCE

Section 2: Monthly Household Income and Current Assets:					
Total # of People in Household:		# of Wage Earners in Home:		# of Dependents:	

MONTHLY Income Sources (after taxes)	BEFORE Diagnosis	AFTER Diagnosis
Your employment:	$	$
Other employment (Spouse/Partner/Other):	$	$
Social Security:	$	$
SSI/SSDI:	$	$
Employer Disability Insurance:	$	$
Unemployment Insurance:	$	$
Spouse Unemployment Insurance:	$	$
Retirement/Pension/401K/IRA/Old Age Pension (OAP):	$	$
Alimony:	$	$
Other Investment Income:	$	$
Other (list here):	$	$
MONTHLY TOTAL INCOME:	$	$

Are you currently enrolled in any of the following programs?	
1. Low-Income Energy Assistance Program (LEAP)	☐ No ☐ Yes
2. Supplemental Nutritional Assistance Program (SNAP)	☐ No ☐ Yes
3. HUD Section 8 / Other Housing Supplement	☐ No ☐ Yes
4. Temporary Aid to Needy Families (TANF)	☐ No ☐ Yes
5. Aid to the Needy and Disabled (AND)	☐ No ☐ Yes

Additional Liquid Assets	Asset Total
Cash / Checking Account:	$
Savings Account:	$
Life Insurance (Cash Value):	$
Investments:	$
Retirement Funds (If not currently retired):	$
TOTAL ASSETS:	$

APPLICATION FOR FINANCIAL ASSISTANCE

Section 3: Monthly Household Expenses:

NON-MEDICAL Expense Type		Estimated Expense (Monthly)
Transportation:	Car Payment	$
	Gasoline	$
	Auto Insurance	$
	Taxi / Other transportation fees	$
Other:	Groceries	$
	Storage Fees	$
	Other:	$
Utilities:	Electricity / Gas	$
	Water	$
	Sewer	$
	Phone	$
	Other:	$
Child Care:	Day care / babysitter / other	$
Housing:	Rent / Mortgage	$
	Home / Renters Insurance	$
	Other:	$

MEDICAL Expenses NOT covered by Insurance	Estimated Expense (Monthly)
Copays / Coinsurance / Deductible Payments	$
Monthly Premiums	$
MONTHLY TOTAL ESTIMATED EXPENSE:	$

Section 4: Signature & Acknowledgment:

I understand that any award is made at the sole discretion of TOUCH INC. I release TOUCH INC. of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize the release of my name, address and medical information or other documentation required by TOUCH INC. for the purpose of verifying this application.

Printed Name:		Signature:		Date:	

APPLICATION FOR FINANCIAL ASSISTANCE

Section 5: Request for Medical Information / Patient Release:

Instructions for the Patient:

Sign your name below and deliver this form to your doctor.

I hereby consent for Dr. _____ to provide the information requested below to TOUCH INC.

I Understand that this information will be kept confidential and is important for the consideration of my application.

Patient Signature (Parent or legal guardian if patient is a minor):	
Date:	

Instructions for the Physician:

Please complete the information below to the extent possible and

Email to: CONTACT@TOUCHINDIANA.ORG

or

Mail to:
TOUCH INC. c/o Cancer Pathways
5740 Vogel Rd.
Evansville, IN 47715

Patient Full Name:	
Specific Cancer Diagnosis:	
Date Diagnosed:	

Cancer treatment administered to date (check all that apply):

☐ Surgery ☐ Chemo ☐ Radiation ☐ Immunotherapy ☐ Clinical Trial ☐ Other (list):

Future treatment required?	☐ Yes ☐ No	**If YES, Plan overview:**	

Will treatment require travel outside of Vanderburgh/Warrick County?	☐ Yes ☐ No
Other comments / Related expenses:	

Physician's Name (Please print):		**Date:**	
Physician's Signature:			