



United Way
of Fulton County
604 S. Shoop Ave # 122
Wauseon, OH 43567

FINANCIAL ASSISTANCE FOR CANCER PATIENTS

SERVICE POLICY

To be eligible for assistance, the cancer patient must be a resident of Fulton County (or an individual who resides outside Fulton County who is employed at a Fulton County worksite that conducts a United Way of Fulton County campaign). Assistance is for individuals whose cancer treatment is causing a financial burden on them or their family. Requests for services and all patient records are CONFIDENTIAL. Assistance to pay for doctors, hospital/nursing home bills, surgery, or any other means of treatment is not provided.

PATIENT ASSISTANCE

DRESSINGS: Reimbursement to patients for commercially prepared dressings, bed pads, or disposable briefs up to \$30 per month for up to 3 months.

PROSTHESIS: Total reimbursement for prosthetic items (i.e. mastectomy supplies, wigs) shall not exceed a total of \$100 per patient.

OSTOMY SUPPLIES: Reimbursement can be made for \$30 per month up to three months.

MEDICATIONS: Patients may receive financial assistance for approved cancer related prescription medications if no other resource is available. Financial payments can be made directly to the patient's pharmacy for up to \$150 per month for up to 4 months.

RADIATION: Patients may receive a one-time reimbursement for the cost of radiation therapy. United Way of Fulton County is able to reimburse you \$200 towards this expense after all insurance has paid (including Medicare/Medicaid). Please submit a Statement of Benefits form from your insurance company that shows what expense the patient is responsible for.

NUTRITIONAL SUPPLEMENTS: Eligible patients may receive financial assistance up to \$100 per month for up to 3 months. This is provided only with authorization from the attending physician.

TRANSPORTATION: United Way of Fulton County may assist at the rate of \$.30 per mile up to \$500 for a 12-month period.



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PATIENT REQUEST FOR FINANCIAL ASSISTANCE

Return to: United Way of Fulton County
604 S. Shoop Ave Suite 122
Wauseon, OH 43567

Date: _____

Name: _____

Address: _____

Phone: _____

What is the patient's worksite? _____

What is the spouse's worksite? _____

What worksite is providing the patient's insurance coverage? _____

This confirms that patient received treatment at:

Name of Treatment Center: _____

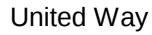
Address: _____

Signature: _____

(Doctor/Nurse/Attendee at treatment center or doctor's office)

Due to the financial burden to myself/family related to the cost of cancer treatment, I/we are requesting financial assistance from the United Way of Fulton County.

Patient (or parent if minor) Signature



United Way of Fulton County will assist at the rate of \$.30 per mile up to \$500.00 for any twelve-month period.