Application

The Smoky Valley Cares Fund: beyond the diagnosis

Patient Information:

NAME _____ DATE OF BIRTH_____

ADDRESS _____ CITY/STATE/ZIP_____

PHONE _____

NAME OF PRIMARY CARE PHYSICIAN_____

NAME OF ONCOLOGIST_____

Applicant/Contact person if different from patient:

NAME_____ RELATION TO PATIENT_____

ADDRESS_____ CITY/STATE/ZIP_____

PHONE:_____

To protect patient privacy, no financial or diagnostic information will be revealed beyond the "need to know" employees that process the application.

Please attach a separate sheet of paper, or write on the reverse of this application page, a brief overview of your need. Please include:

- A diagnosis
- Your condition today
- A brief statement of financial need, including information about medical insurance and expenses not covered by the policy.
- A listing of expenses, actual or anticipated, for which funding is requested

"I have been diagnosed with cancer (or am submitting this application of behalf of a someone who has been diagnosed with cancer) and request assistance with costs associated with my treatment. With my signature, I hereby give permission to the staff of the Lindsborg Community Hospital to contact the parties listed in this application or attachments strictly for purposes of verification."

_____

Signature of applicant date

Covered Needs List

Items covered by SVC funds. Please keep this form for your reference

Nutrition

- Food, healthy beverages
- Dietary supplements
- Prepared meals, meal preparation

Shelter

- Rent/mortgage payment
- Utilities
- Necessary handicap accessibility addition, improvement
- Repair to HVAC, electrical, plumbing

Medicine

- Medical and dental care that is not otherwise covered by, but not limited to prescription and non-prescription medicine, hospital and hospice care, nursing or attendant care.

Transportation

- Costs associated with transportation to and from treatment and/or medical care, including fuel, repair, tires, service, cab or bus fare

Smoky Valley Cares Fund

Physician Verification, Patient Eligibility

THIS FORM IS TO BE COMPLETED AND RETURNED BY THE PHYSICIAN

DATE:_____

PHYSICIAN'S NAME_____
MAILING ADDRESS_____
_____

SUBJECT: Eligibility Verification

The Lindsborg Community Hospital offers assistance from the Smoky Valley Cares Fund to grant individuals actively undergoing treatment for cancer. The funding is intended to provide assistance to a patient for the basic needs of health and well-being: nutrition, transportation, shelter and medicine. The funding will be at the discretion of the administrators of the Fund and will be issued in the form of a check. A recipient may receive a total of $500 for each 12 month period they are receiving treatments.

Your patient, _____, has applied for benefits from the fund. In order to ensure funds are distributed to recipients meeting the criteria, please verify the patient has a cancer or cancer-related illness by signing below and retuning this letter in the enclosed envelope. It must be received by a means *other than being delivered by the patient*; mailed to LCH at 605 W Lincoln, ATTN: Smoky Valley Cares Fund, Lindsborg, KS 67456 OR by FAX, 785-227-4130.

For questions regarding this fund, pleased contact Laraine Gengler, CFO, at Lindsborg Community Hospital, 785-227-3308 ext 110 or hospital Administrator, Larry Van Der Wege at 785-227-3308 ext. 100.

Sincerely,

Betty Nelson
Director of Marketing & Development
Lindsborg Community Hospital

___Yes, _____ does have a cancer or cancer-related illness
___No, _____ does not have a cancer or cancer-related illness.

_____

PHYSICIAN SIGNATURE DATE