



**Maryland Cancer Fund Cancer Treatment Application for
An Individual
For Funding of Direct Payment for Cancer Treatment of an
Individual Patient (not using Maryland Health Insurance Plan) (“Non-MHIP Treatment Application”)**

**PLEASE COMPLETE ALL AREAS OF THE APPLICATION, Pages 1-3
(IF SOME AREAS DO NOT APPLY TO THE PATIENT, PLEASE MARK Not Applicable)**

Instructions:

- PAGE 1:* **RESIDENCY ELIGIBILITY** – The patient receiving payment for treatment through the Maryland Cancer Fund (MCF) must be a Maryland resident.
Please provide a copy of ONE of the following documents displaying patient’s name AND current home address:
- Maryland Driver’s License
 - Maryland State Identification Card (issued no fewer than 6 months before the application date)
 - Lease or Rental Agreement
 - Property Tax Bill
 - Motor Vehicle Registration
 - Paycheck or Stub with Full Name and Home Address
 - Utility Bill (i.e. Gas and/or Electric Bill, Water Bill, Telephone Bill- residence phone only)
 - Voter Registration Card
 - W-2 Statement (not more than 12 months old)
- PAGE 2:* **INSURANCE ELIGIBILITY** – The patient is only eligible for the MCF Treatment Grant if the patient has no health insurance at the time of application for the grant and remains uninsured at the time of service delivery.
- PAGE 2:* **ANNUAL FAMILY INCOME** – Please list the total amount received from all sources before taxes are withheld. The patient must have an annual family income of not more than 250 percent of the federal poverty guidelines.
- PAGE 2:* **FINANCIAL ELIGIBILITY** – Proof of annual family income for the patient, including a copy of **at least one** of the following:
- **Two Pay-stubs** – Must be for two pays in a row or in the most recent month or two pays in the same month
 - **Most recent income tax return**
 - **Most recent W-2 form**
 - **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount the patient will receive each month.
 - **Notarized Statement** – If the patient is not working, this statement should state that the patient is **not** working and does **not** have **any** income, or that the patient has not had any income in the past 6 months. This is a legal document and must be stamped and signed by a notary public. (See sample patient’s statement DHMH Form 4685).
- PAGE 2:* **FAMILY COMPOSITION** – To determine eligibility, please provide the number of individuals in the family of the patient needing treatment.
- PAGE 3:* **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. The patient’s signature indicates: (1) the statements that the patient made are true; (2) the MCF has the patient’s permission to verify the patient’s information provided; and (3) the organization applying on behalf of the patient has the patient’s permission to release information regarding the patient’s medical, financial, and insurance information to in the MCF.

MARYLAND CANCER FUND Non-MHIP Treatment Application for an Individual Patient
Maryland State Department of Health and Mental Hygiene
Family Health Administration

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PATIENT INFORMATION (Please type or print)

Name: _____
Last First MI

Date of Birth: //
MM DD YYYY

Sex: Male
 Female

Marital: Separated
 Divorced
 Married
 Single/Never Married
 Widowed

Ethnicity: Hispanic or Latino
 Not Hispanic or Latino
 Unknown

Check all that apply:

Race: White
 Black or African American
 Asian
 American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander
 Other (Specify) _____

Patient Currently Employed: Yes No

If yes, place of employment: _____

If employed, how long? _____

Spouse Employed: Yes No

If yes, place of employment: _____

If employed, how long? _____

Home Address: _____
Number, Street / P.O.Box

_____ City/Town State Zip Code County of Residence

Maryland Resident: Yes No

Home Phone: /

Work Phone: / Ext:

Cell Phone: / E-Mail: _____

EMERGENCY CONTACT

Name: _____ Phone: /
Last First

Address: _____

Relationship to Patient: Spouse Parent Child Other (Specify): _____

Contact Person for Organization Applying:

Name: _____ Phone: /
First Last

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Patient Name: _____
 Date of Birth: _____

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INSURANCE ELIGIBILITY: Do you have any health insurance? Yes: _____ No
ANNUAL FAMILY INCOME: The total amount received per year from all sources before taxes are withheld.

	INCOME (Please indicate week, month or year)			FOR OFFICE USE ONLY DOCUMENTATION	
		<input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	Yearly Total: \$.		
Patient Income (Includes Social Security and any other retirement benefits)	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Spouse's Income (Includes Social Security and any other retirement benefits)	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Parents' Income (If patient is a dependent child on parents' income tax return)	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Child Support	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Foster Child Supplement (If child(ren) counted in household composition)	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Unemployment Insurance <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$.		Yearly Total: \$.	Start Date: _____ End Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Workman's Compensation <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$.		Yearly Total: \$.	Start Date: _____ End Date: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Social Security Disability Insurance <input type="checkbox"/> dependent child <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
Alimony <input type="checkbox"/> patient <input type="checkbox"/> spouse <input type="checkbox"/> parent	\$.		Yearly Total: \$.		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Initial: _____
TOTAL ANNUAL FAMILY INCOME			\$.		

FINANCIAL ELIGIBILITY

In order to determine your financial eligibility for this program we need to collect information regarding household composition and family-income. **PROOF OF INCOME MUST BE ATTACHED – (Your most recent Income Tax Return is preferred.** However, W-2 Forms, Social Security Entitlement Letter, a minimum of 2 Pay Stubs in a row or in the most recent month, or a notarized letter stating “No Income and No Employment” can be substituted).

FAMILY COMPOSITION

Please list the names and ages of all family members. For a financially independent adult 18 years old or older diagnosed with cancer and one or more of the following: spouse; financially dependent child; or financially dependent relative. For a financially dependent child, the child and one or more of the following: parent, foster parent, or guardian; sibling living in the household; or half brother or half sister living in the household and indicate their relationship to the patient.

LAST NAME	FIRST NAME	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			

If there are more than five residing in your household, please attach a list of other dependents listed on your Income Tax Return with their name, age and relationship to patient.

Total number of people in family (including patient):

Patient Name: _____
Date of Birth: _____

State of Maryland
Maryland Cancer Fund Non-MHIP Treatment Application for an Individual Patient
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PATIENT AGREEMENT
(Please read carefully before signing)

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under State law and would result in a denial of grant eligibility.

I authorize the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control, Maryland Cancer Fund (MCF) to verify any information provided by me on this form. I will provide proof of any information on this form as required by the MCF.

I agree to allow the _____
Name of Organization

to release the medical/financial/insurance information regarding my cancer treatment and the Maryland Department of Health and Mental Hygiene that administers the Maryland Cancer Fund.

Signature of Patient or Parent/Guardian

Name of Patient
(Please Print or Type)

Date of Application

Name of Contact Person for Organization Applying
(Please Print or Type)

Address of Contact Person
(Please Print or Type)

Office Phone of Contact Person

RETURN COMPLETED MCF APPLICATION TO:

**Maryland Cancer Fund
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 400
Baltimore, Maryland 21201**

For questions, please call (410) 767-6213