Young Adult Cancer Support (YACS) Pittsburgh, sponsored by the Cancer Caring Center, awards young adult cancer patients and survivors, aged 18-39, with financial assistance grants to assist with the financial burden that cancer causes. Each grant covers $300.00 worth of treatment and/or non-treatment related needs that are not covered by insurance, including (but not limited to): copays, rent, utilities, medical bills, groceries, transportation, etc. Funds are extremely limited, based on availability, and are only offered to those who meet all qualifications.

YACS Pittsburgh: 2019 Financial Assistance Grant Application

YACS Pittsburgh Grants:

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Application Process:

Qualifications for Assistance:

- Applicants must be between the ages of 18 and 39 at the time of diagnosis and application.
- Applicants must be a current resident of one of the following counties in PA: Allegheny, Armstrong, Beaver, Butler, Fayette, Washington, Westmoreland.
- Applicants must submit a completed financial assistance application.
  *Please print clearly, as illegible applications will not be processed.
  *A medical oncology professional must complete and sign the medical information section.
  *Please note the address and fax number on the application for submitting once completed.

YACS Pittsburgh is an independent program sponsored by the Cancer Caring Center, a local Pittsburgh charity that offers free emotional support to cancer patients, survivors, and their loved ones. YACS Pittsburgh grant applications may be found here: www.cancercaring.org/YACS or by calling 412-622-1212. All applications are reviewed on a first come, first served basis and will be approved based on qualifications and documentation of need. Applicants may only apply and be awarded annually unless notified otherwise.
Patient Section: (please print clearly)

First Name: ___________________________ Last Name: ___________________________

Current Street Address: ___________________________ City: ___________________________

County of Residence: ___________________________ State, Zip: _______________________

Date of Birth: __/__/____, Age: __

Phone Number: (daytime) ____________ (evening) ____________ (work) ____________

Email Address: ___________________________ Occupation: ___________________________

Please check one:  □ Male  □ Female

Ethnicity (optional): ___ White ___ African-American ___ Latino ___ Asian ___ Other

Medical Section: MUST be completed by one of your medical oncology professionals. (i.e. oncology doctor, nurse, or social worker)

Date of Diagnosis: __________ Primary Cancer: __________ Current Stage: __________

Diagnosis:  □ New  □ Recurrence  Is the patient currently in treatment?  □ Yes  □ No

If currently in treatment, please indicate type of treatment:

________________________________________________________________________________

If not in current treatment, how often is the patient required to follow-up? ____________________

Name of patient’s MD (please print): ___________________________ Facility Name: ___________________________

Street Address: ___________________________ City: __________________ State, Zip: _______________________

Phone Number: ____________ Fax: ____________

Name & title of person completing this section (please print): _____________________________

Phone Number: ____________

Signature of Medical Professional: __________________ Date: __/__/____

(As of 01/2018)
Applicant's Name: _________________________________

Date of Birth: __/__/____

Application for Financial Assistance, page 2

Patient Section, continued:

Does the patient currently have health insurance? ___ Yes    ___ No

*If “yes”, are prescription drugs covered? ___ Yes    ___ No

Number of people in patient’s household: _____

Monthly Household Income: $_________

Statement of Need:

Please give a brief description of need for financial assistance (print clearly):

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Funding is extremely limited, based on availability, and on applications that meet all YACS Pittsburgh Qualifications for Assistance (refer to page 1). By signing this application, the patient verifies that all information is accurate to the best of his/her knowledge. The patient also gives permission for a Cancer Caring Center representative to verify any and all information included in the application. After review, a Cancer Caring Center representative will contact the person requesting assistance. Thank You!

Signature: of Applicant: _________________________________ date: __/__/____

Mail application to: Cancer Caring Center, 4117 Liberty Avenue, Pittsburgh, PA 15224