4117 Liberty Avenue, Pittsburgh, PA 15224

(email) yacspittsburgh@gmail.com

(web) www.cancercaring.org

(tel) 412-622-1212 **(fax)** 412-622-1216

YACS Pittsburgh:

2018 Financial Assistance Grant Application

YACS Pittsburgh Grants:

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.

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.*

(As of 01/2018)

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Application for Financial Assistance, page 1

Patient Section: (please print clearly) **Today's date: __/__/____**

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: __/__/____

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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
or Fax to: 412-622-1216