

## 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 on behalf of 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."*

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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 returning 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, please contact Laraine Gengler, CFO, at Lindsborg Community Hospital, 785-227-3308 ext. 110 or the hospital Administrator, Mark Rooker 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