Assistance In Healthcare
Arizona
Offering Cancer Patients Assistance with Non-Medical Expenses

AAHC members are volunteers who raise funds to help defray the non-medical expenses of patients actively receiving cancer treatment. It is supported through the fund-raising efforts of its members and other donations.

A few things you should know: (Read carefully --- please!)

1. The AAHC Application Committee typically reviews submitted applications on the second Friday of every month.
2. Present your completed application to your care provider at the time of your visit for the physician certification portion of the application.
3. Mail your application to: Assistance In Healthcare, Inc.
   P.O. Box 5157
   Goodyear, Arizona 85338
4. To allow enough time to review, process and copy your application, the AHHC Application Committee must have it by the end of business on the First Friday of every month. Late applications will be treated as LATE and will be considered at the meeting on the following month.
5. You must have received treatment at a Phoenix area medical facility **within the last 30 days** to be eligible to apply for assistance.
6. The committee will accept only one application per patient each month.
7. Please ensure the entire application form is completed. Incomplete forms will not be considered. EVEN the SECTION on “How this will help you!”. (pg 3)
8. Each request is reviewed individually.
9. The amount of assistance granted will depend on the amount of funds available and the financial status of the applicant but will not exceed $250. Check will need to be cash with 90 days after 90 days the check will be voided.
10. Applying **does not guarantee you will receive funds.**
11. The information you provide on your application is kept in the strictest confidence. Please allow us the same courtesy with regards to the amount of funds provided to you (don’t tell others how much you received).
12. **Arizona Assistance in Health Care cannot help you with any doctor bill, hospital bill, insurance premium, prescription or other medical expenses.**
13. Address any question regarding your application to 623-207-3009 or email info@AzAssistanceinHealthcare.com

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*****INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED** APPLICATIONS MUST BE RECEIVED BY THE LAST FRIDAY OF EACH MONTH FOR CONSIDERATION THE FOLLOWING MONTH.***

Original Applications Each Month only (all pages must be original – no copies) – please do not resubmit previous month's applications.

Today's Date _____

Patient's Name _____ Age _____

Applicant's Name _____ Age _____

Applicant's Phone number (____) _____ Applicant's **SS#** _____

Applicant's Address _____

City _____ State _____ Zip _____

Diagnosis and condition of patient _____

_____

Applicant's relationship to Patient _____

No. living in household _____ Ages of dependent children in household _____

Others financially dependent on applicant _____

Is the patient currently:
□ employed and working full time
□ employed but on FMLA/Disability/Leave
Employed: □Full Time □Part Time
□Unemployed □Disabled

	APPLICANT	SPOUSE	OTHER PERSONS
Employer			
Type of Work			

ASSETS (List **CURRENT VALUE**):

Checking Accounts	$		
Savings Accounts	$		
Other Investments/ Liquid Accts	$		

SOURCES OF INCOME (**List MONTHLY amounts**):

	APPLICANT	SPOUSE	OTHER PERSONS
Net Wages **(after taxes)**			
Unemployment			
Sick Pay			
Social Security			
Short/Long term disability			
Retirement Benefits			
Rental Income			
Investment Income			
Interest Income			
Alimony			
Child Support			
Trust Funds			
Room/Board			
Welfare			
Military Benefits			
Other:			
TOTAL			

EXPENSES (List **MONTHLY** amounts):

Rent or Mortgage			
Gas			
Electric			
Sewer and Water			
Telephone & Cell			
Car Payments			
Car Insurance			
Gasoline and Oil			
Food			
Health Insurance			
Life Insurance			
Medications			
Prescribed Vitamins			
Child Care			
***Other Debts (**payments**)			
TOTAL			

***OTHER DEBTS (i.e., credit cards, medical bills, loans, etc.) List **FULL BALANCES**

_____

_____

_____

_____

_____

Note: Arizona Assistance in Health Care, Inc. cannot assist with payment of Hospital Bills, Doctor Bills, Medication Expenses, Travel Expenses, and/or Lodging Expenses.

By my signature, I certify that all information provided is complete and accurate to the best of my knowledge. I understand that Arizona Assistance in Healthcare, Inc. ("AAHC") is not required to render any assistance to me and that I will remain responsible for payment of all bills. By accepting this application, AAHC has assumed no responsibility for payment of any bills.

_____
Applicant's Name Printed

_____
Applicant's Signature

~~All information must be complete for application to be processed~~
~~Please attach a copy of the bill you need assistance with~~
~Only patients currently undergoing cancer treatment will be considered for assistance~

Please return application to:
Arizona Assistance in Health Care, Inc.
P.O. Box 5157
Goodyear, AZ 85338

Please let us know how this will help you. Please be as specific as possible as to why you need this grant, specifying food, rent or other non-medical emergency needs:

□**Rent** □**Food**

□**Utilities** □**Credit Card Debt**

Other:_____
_____
_____
_____

□ I am willing to share my story. *(Financial information will NOT be shared)*

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PATIENT AUTHORIZATION

I hereby authorize the physician(s) or physician groups noted below to verify my status as a cancer patient, my diagnosis, and to discuss the anticipated duration of my treatment with Arizona Assistance in Healthcare, Inc. and its representatives.

Patient Name:_____

Address:_____

Home Phone:_____ Work Phone:_____

Physician Name:_____

Office Address:_____

Office Telephone Number:_____

Office Fax:_____

Patient Signature:_____date:_____

(This section for physician/clinician only)

PHYSICIAN CERTIFICATION

I certify that _____(patient name) is being ***ACTIVELY* *(not maintenance)* treated for _____(cancer-related diagnosis).**

Treatment type: (please check all that apply)

_____ IV Chemotherapy _____Surgery: date_____
_____Oral Chemotherapy _____Radiation Therapy

The patient is expected to be under active treatment for _____(time frame).
Applications without a time frame will not be considered.

_____ _____
Physician Signature **Date**
(must be physician signature – cannot be stamped or nurse signature)
(physician signature and date must be within last 60 days)

Physician Name (printed):_____