# NPCF's Critical Funding Request - Financial Assistance Program

This Patient Assistance Program provides direct financial support for approved patients who are currently diagnosed and undergoing treatment for pancreatic cancer. If you or a loved one is facing pancreatic cancer and are experiencing a financial hardship, we may be able to help. The Critical Funding Request FAP helps eligible pancreatic cancer patients with a **one-time unforeseen financial need.**

**We may cover the following expenses:** home repairs, vehicle repairs, funeral expenses, moving deposits, PEMF Therapy, alternative therapies, Etc.

**We do not cover the following expenses**: insurance premiums, medications, co-pays, medical bills, and other bills determined not applicable.

## Critical Funding Request - Financial Assistance Program Standards

- Applicant must be a United States citizen, living in the United States.
- Applications completed in any foreign language will not be considered.
- Any inaccurate or misleading information provided in an application will automatically terminate qualification for financial assistance.
- The application must be completed in full, and all required documents submitted. Incomplete applications will NOT be considered.
- Signatures must be original. Faxed or copied doctor's signatures will not be accepted.
- Individuals may apply online at https://www.npcf.us/programs/financial-resources/ or through a mail-in application process.
- The financial assistance program is designed as a one-time use benefit. Applicants **should not** reapply for assistance after the benefits have been exhausted.
- Applications are reviewed weekly. If you have questions, please contact us at assistance@npcf.us or call 1-800-859-6723.
- Communication about you application, documentation or billing will be sent via your account portal at https://www.npcf.us/programs/financial-resources/ , by email or phone call.
- An email address is required to communicate and create your account portal. A confirmation email will be sent to all applicants upon receipt of application and will include further instructions. If you do not receive a confirmation email, please check your junk/spam folder.
- Testimonials may be required from the applicant at the Approval Committee's request.
- This Assistance Program is available due to the generosity of our donors and volunteers. The committee reserves the right to distribute assistance amounts based on funds available at the time of the request. Partial funding may occur. We may have "open and closed" periods. If there is a period when the program is closed, notification will be posted on the Assistance page of NPCF.us. The website will serve as the official notice for the Patient Assistance Program.

NATIONAL PANCREATIC CANCER FOUNDATION

# Application for Critical Funding Request – FAP Checklist

**Applicants must provide a copy of each of the following items to be considered for this program.**

- ❑ Completed Application for Patient Assistance Program form. (see below)
- ❑ Proof of US Citizenship (copy of birth certificate or passport)
- ❑ Copy of Drivers License or State Identification Card
- ❑ Doctor's statement. Statement must be on treating doctor's letterhead, advising that you are currently receiving treatment for pancreatic cancer and the date of diagnosis. *** *Must be an original signature by the doctor (you can upload a copy for now but the original must be mailed to P.O. Box 1848, Longmont, CO 80502 prior to dispersing funding.. ****
- ❑ Statement of Need. A written and signed letter of explanation from the applicant regarding the current situation and need for financial assistance. **Letters without the applicant's signature with not be accepted.**
- ❑ Provide a copy of the billing invoice or estimates you are requesting assistance with.
- ❑ When applicable, particularly with repairs, 3 estimates will be required for submission prior to final funding decisions being made. Please call us at 1-800-859-6723 if you have questions regarding this policy and your request.

**Applications missing any of the above documented items will not be processed or approved.**

## All documents must be mailed to:

**National Pancreatic Cancer Foundation**
**Patient Assistance Program**
**1760 Centre Street Suite A**
**Rapid City, South Dakota 57703**


# Application for Critical Funding Request - FAP

*** Please note **all** items on this form are required to process your application. ***

## Patient Information

**First Name: _____ Middle Initial: _____**

**Last Name _____ Suffix : _____**

**Household Size: _____ Phone Number: _____**

**Email **required** : _____**

**Street Address: _____**

**City: _____ State: _____ Zip: _____**

## Assets **Provide Current Balances in Financial Accounts:**

**Checking: _____Savings: _____Retirement Accounts: _____**

## Medical Information

**Diagnosis: _____**

**Date of Diagnosis: _____**

**Physician's Name: _____**

**Physician's Phone: _____**

**Medical Facility: _____**

**Additional Information or Comments: _____**