NPCF's Patient Assistance Program

The Patient Assistance Program provides direct financial support for approved patients who are currently diagnosed and undergoing treatment for pancreatic cancer. Our hope is to reduce some of the daily stress that patients and their families face by assisting with essential billed living expenses.

Bills that are eligible for payment through our Patient Assistance Program are:

- Rent or Mortgage Bills (we cannot consider mortgage that is in foreclosure or bankruptcy)
- Phone (phone bills that include cable or internet will not be considered. Please provide a breakdown of the actual cost of the phone line.)
- Electric Bills
- Gas Bills
- Water Bills

The NPCF does NOT provide financial assistance for any of the following: insurance company bills, hospital bills, co-pays, collection accounts, credit cards, cable bills, cell phone bills (unless the cell phone is the primary phone).

Upon approval, no bills will be automatically paid each month. Current billing statements **must** be submitted monthly to be eligible for payment.

2022 INCOME GUIDELINES

***** Income eligibility guidelines are based on the Federal Poverty Income standards. *****

- The applicant must have no more than $5,000 total liquid assets (cash, checking, and/or savings accounts, etc.).
- The applicant's annual household income must be less than 200% of the national poverty level. The table below shows the 200% of Federal Poverty Income guidelines:

Household Size	Weekly	Monthly	Annually
1	$ 490.77	$ 2,126.66	$ 25,520
2	$ 663.07	$ 2,873.33	$ 34,480
3	$ 835.38	$ 3,4620.00	$ 43,440
4	$ 1,007.69	$ 4,366.66	$ 52,400
5	$ 1,180.00	$ 5,116.33	$ 70,320
6	$ 1,352.30	$ 5,860.00	$ 79,280
For each additional person in household, add			$ 4,480

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Patient 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.
- Income eligibility guidelines must be met to be considered for approval.
- 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.
- Applicants that are approved are allowed 3 consecutive months of financial assistance.
- Upon approval, no bills will be automatically paid each month. Current billing statements **must** be submitted monthly to be eligible for payment.
- 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 and 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.

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Application for Patient Assistance Program 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) (color copy required)
- ❑ Copy of Drivers License or State Identification Card (color copy required)
- ❑ Proof of income for every adult residing in the household (social security letter, paystub, etc.)
- ❑ Complete Bank statements for every adult residing in the household (most recent three months for each account) **** Please note that we do not need proof of income and banking information for unrelated roommates, and they will not be included in the household size. We require an explanation of how bills and rent are handled between roommates that are unrelated to the patient and only partial (split) assistance will be considered. ****
- ❑ Doctor's statement. Statement must be on treating doctor's letterhead, advising that you are currently receiving treatment for pancreatic cancer. **** 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 your second month of assistance being approved. ****
- ❑ Statement of Need. A note written by the applicant explaining the current situational need.
- ❑ Rental agreement or lease (only required of those requesting assistance for rent)
- ❑ Copies of all bills for which you are requesting assistance. **Bills must be in patient or spouses' name.** **** We cannot consider bills that are on an automatic payment system with the creditor. We do not offer reimbursement for any bills already paid. Current statements with the amount due must be submitted with your application. If you were approved for assistance in a prior month, you need to provide us only the new and current month billing statements. ****
- ❑ Completed Billing Summary Sheets, if applying by mail.

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 Patient Assistance Program

*** 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: _____

Medical Information

Diagnosis: _____

Physician's Name: _____

Medical Facility: _____

Physician's Phone: _____

Additional Information or Comments: _____

Billing Summary Sheet

Patient Name: _____ Date: _____

***** Please fill out and return with copies of current billing statements. *****

Name of Creditor: _____

Account Number: _____

Payment Address: _____

Bill Amount: _____ Billing Due Date: _____

Billing Category (Circle one): Rent Mortgage Electric Water Gas Sanitation Phone

Name of Creditor: _____

Account Number: _____

Payment Address: _____

Bill Amount: _____ Billing Due Date: _____

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