The HOPE CHEST for WOMEN helps patients with significant financial need defray treatment-related expenses including; incidental costs not covered by other assistance programs, transportation, supplements, lymphedema garments, testing approved medications, chemotherapy, and radiation therapy not covered by insurance or other sources.

Through this program, financial assistance, relevant education, and support services are offered to medically underserved women who are in need of support during treatment for cancer.

Who is Eligible for Assistance?

You may qualify for assistance through the Hope Chest Assistance Program if you:

- reside in western North Carolina
- are a woman receiving treatment for breast cancer
- are you receiving treatment for cervical, endometrial, fallopian tube, ovarian, uterine,
- vaginal, or vulvar cancer
- are uninsured, underinsured, or need financial assistance
- must provide doctor pathology report

If you have private insurance, you may receive aid for treatment-related costs that are not covered through other payment sources. Other eligibility requirements might apply.

All Required documents must be submitted with your application to receive assistance. Please send all of these items listed below in order to expedite your application.

- Hope Chest Application
- Information Release Statement
- Income Statement is needed from every applicant (Copy of recently filed taxes, most recent pay stub, retirement or disability statement or bank statement) Level of income will not disqualify you for help.
- Pathology Report and Progress Notes
- Letter of Medical Necessity, if applicable
- A copy of bill(s) with payment instructions must be sent to us in order to provide bill pay assistance, payment could take over two weeks for approval.

Submit your application to
The Hope Chest for Women
P.O. Box 5294
Asheville, NC 28813

Your application will be approved after all supporting documents are submitted. Payments will be made to providers of service (i.e. pharmacy, lab, hospital, and physician). Funds are subject to availability. A new application is required every calendar year with supporting documentation. You will be given additional resource referrals based on your individual needs.

All decisions for disbursements to eligible patients are at the discretion of The Hope Chest board.

The Hope Chest for Women 2025 Assistance Application
Please complete ALL information and print legibly.

Patient Information

First Name: _________________MI _______ Last Name: _______________________ Last 4 of SS#_______

Birth date: ________________ Age: ______________ Ethnicity: ________________________

Mailing Address: ____

City: _________________________ County: _______________ State: _______ Zip: ______________

Street Address (if different): ____

E-Mail Address: ____

Home Phone: ___________________ Work Phone: ___________________ Cell Phone: __________________

Diagnosis (Type of cancer): ________________________ Physician (Oncologist): _______________________

Date of diagnosis: __________ Stage at diagnosis: ______________

Current treatment:

____

____

Insurance Information

Insurance Company: _______________________________ ID Number: _______________________________

Do you have a prescription drug plan? ☐ Yes ☐ No Type of plan:

____

Do you receive state assistance? ☐ Yes ☐ No Do you receive assistance from other sources? ☐ Yes ☐ No

If yes, please list: ____

Financial and Household Information

Total Monthly Net Family Income: $__________________ Total number in household: _____________

Number of Adults: ______________

Total Family Liquid Assets: (not car) $________________ Number of Children: ___________

Ages of Children: ______________

Out-of-Pocket Medical Expenses: $_____________/month Current Employment Status: ________________

Funding Request

What kind of assistance do you need? Please be specific:____

____

____

____

Who referred you to The Hope Chest? ________________________________ Phone: ____________________

I attest to the above information being correct and complete to the best of my knowledge.

____ ________________________

Applicant Signature **Date**

Please include required documents (see cover letter) and any applicable information with this form.

The Hope Chest for Women

Information Release Statement

By my signature, I authorize the release of the information provided on my application to The Hope Chest and I authorize The Hope Chest to use same information to contact my insurer, other potential funding sources, social workers, or patient advocacy organizations on my behalf to determine my eligibility for alternative financial support through The Hope Chest.

I also authorize The Hope Chest to contact my insurer, health care provider, or dispensing agent, and I authorize aforementioned entities to disclose information to The Hope Chest, relative to my medical condition, treatment or drug therapy as requested by The Hope Chest. Disclosure of this information may include, but is not limited to, the electronic transmission of information. The Hope Chest agrees to request only that information needed to process this application, to renew it, and to provide continued assistance during my participation in the program. The Hope Chest also agrees not to disclose any information obtained from these sources to any third party except as authorized by me or as required by applicable law.

This authorization shall continue in effect until final decisions have been made regarding this application. I understand that submitting this application does not guarantee financial or other support from The Hope Chest**.**

Applicant's Name: ____ Date: ____________________

Signature

____

Print Name

I also grant permission for The Hope Chest to discuss my application with the following:

1.____ ____________________________________

Name **Relationship**

2.____ ____________________________________

Name **Relationship**

May we leave a message on your answering machine or cell phone? Yes_____ No_____

I authorize the following to be released:

- Pathology Report(s)
- Most Recent Progress Notes

TO: **FROM:**

The Hope Chest for Women, Inc.______________________________

P. O. Box 5294______________________________

Asheville, NC 28813______________________________

____ ________________________

Printed Patient Name Date of Birth

____ ________________________

Patient Signature Date Signed