APPLICATION FOR FINANCIAL ASSISTANCE FROM THE L.Y.N. FUND, INC.

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ Social Security # _____

Street Address: _____ City: _____

State: _____ County**: _____ Zip: _____

**THE L.Y.N. FUND PROVIDES ASSISTANCE TO RESIDENTS OF PINELLAS OR PASCO COUNTY, FLORIDA ONLY.
IF YOU RESIDE IN ANY OTHER COUNTY OR STATE, PLEASE STOP HERE.**

E-Mail Address: _____

Home Phone: _____ Cell Phone: _____

Employment Status **BEFORE** your cancer diagnosis: (*Please check one*)
❒ Full Time ❒ Part Time ❒ Retired ❒ Self-Employed (full or part time) ❒ Unemployed
❒ Disability / Sick leave ❒ FMLA

Please provide the name and address of your Employer, including a primary contact person, their phone number and e-mail address:

_____
_____
_____
_____

CURRENT Employment Status (*check one):*
❒ Full Time ❒ Part Time ❒ Retired ❒ Self-Employed (full or part time) ❒ Unemployed
❒ Disability / Sick leave ❒ FMLA

Month/Date/Year you last worked: _____
If on disability/sick leave, are you receiving any compensation: ❒ Yes ❒ No

Marital Status (*check one*): ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partnered ❒ Separated
# of Wage Earners in Household: _____ Total # of people living in household: _____

Number and Age of Dependents in Household: _____

Disability Insurance *(NOT Social Security Insurance Disability or SSID)*: ❒ Yes ❒ No
If yes, fill in your waiting period _____

How much Disability Insurance is received per week/month? _____

How many months? _____

HEALTH INSURANCE (*check one):*
❒ None ❒ Medicare ❒ Medicaid ❒ Supplied by Employer/Spouse's Employer ❒ Private

Other Insurance Company:_____

Applicant Name: _____

MEDICAL INFORMATION:

Please have this page filled out by your Oncologist, Patient Advocate or Nurse Navigator.

Current Diagnosis:

Date Diagnosed: _____ Type of Cancer_____

Stage/Grade: _____

Chemotherapy: Start Date: _____ End Date: _____

Radiation: Start Date: _____ End Date: _____

Other Therapy or treatment details: _____

Form Completed by: _____
Signature

_____
Name (please print)

_____
Phone

_____
Hospital or Oncology office

_____
Date

Applicant Name: _____

ADDITIONAL MEDICAL CONTACTS:

Please provide the Name, e-mail address AND phone number for the following providers with whom we may discuss your application. If we can't reach you or need further information (also complete the HIPPA release form, page 7).

Surgeon:

Name: _____

Email: _____

Phone: _____

Oncologist / Oncology Nurse:

Name: _____

Email: _____

Phone: _____

Other Contact(s):

_____ _____

Please read these items carefully and check the boxes that are true:

- ☐ I understand The L.Y.N. Fund does not pay for medical expenses of any kind.
- ☐ I am currently a patient either recovering from a cancer-related surgery, and/or I am currently undergoing chemotherapy or radiation.
- ☐ I give my full authorization and permission to The L.Y.N. Fund to obtain the necessary medical information to process my application.
- ☐ I understand that The L.Y.N. Fund may ask personal questions about my treatment and financial status. I agree to provide accurate answers

Applicant's Signature: _____ Date: _____

****You must also complete the Financial Disclosure Form, The HIPAA Authorization Form and provide all documents requested.* ***Please include a copy of your driver license with this application.*** *And, we encourage you to include and submit your personal story, please use a separate sheet to add it to your application.****

Applicant Name: _____

FINANCIAL DISCLOSURE FORM:

Monthly Income	**Self**	**Partner**	**Total (Partner & Self)**
Salaries			
Social Security Disability and/or State Disability			
Workers Compensation			
Pension and/or Annuity Payments			
Alimony			
Child Support			
Interest/Dividends from assets / Gross rent from rentals properties			
Disability Policy benefits or sick pay from Employer			
Total Monthly Income:			

Expense	**Monthly Amount**	**Expense**	**Monthly Amount**
Mortgage / Rent		Home Insurance	
Car Payment		Car Insurance	
Health Insurance		Groceries	
Electric		Cell Phone	
Water/Sewer		Home Phone	
Internet/Cable		Child Support Payments	
Gas		Monthly Medical Expenses *Use separate sheet but include total here*	
Trash		Other: _____	
Other: _____		Other: _____	
		Total Monthly Expenses:	

Total Monthly Net Income (Income less Expenses)

REQUEST FOR FUNDING INFORMATION

Applicant Name: _____

Please rank which expenses you'd like The L.Y.N. Fund to consider paying that would provide the most financial relief. **Please rank your priorities using numbers – starting with 1 as the most helpful**. Please note that The L.Y.N. Fund does not pay any credit card accounts or medical related bills.

Priority/Rank	Bill Type	Paid To
	Mortgage / Rent	
	Car Payment	
	Electric	
	Gas	
	Water/Sewer	
	Trash Service	
	Internet/Cable	
	Home Phone	
	Cell phone	
	Car Insurance	
	Other:	
	Other:	
	Other:	

Please list other organizations to which you have applied for assistance:

_____

_____

_____

APPLICANT RELEASE FORM:

1. I, _____ hereby grant The L.Y.N. Fund, Inc., its agents, community and business partners, subsidiaries and affiliates, and their respective licensees, , successors and assigns the right to use, disclose, maintain, copy, publish, transmit, copyright and permit others to use my image, likeness, name, and personal information, including my story about The L.Y.N. Fund, Inc. and the grant/contribution that I received for commercial or non-commercial purposes, including advertising, public relations, promotion of The L.Y.N. Fund, Inc., its products and services and its partners or affiliates. This will extend to any medium or format whatsoever, including without limitation, in and on magazines, brochures, and other print publications, press releases, electronic media, and he internet (including the website and social media sites of The L.Y.N. Fund, Inc.
2. I further agree and do hereby release and hold harmless The L.Y.N. Fund, Inc. from any and all claims, actions, suits, liabilities or damages arising from use of the Content and weather resulting from the negligence of The L.Y.N. Fund, Inc. or any other person, I waive any right I may have to make or bring any claim against The L.Y.N. Fund, Inc. relating to its use of the Content. I understand and agree that I will not be compensated in any way for providing the Content to The L.Y.N. Fund, Inc. or authorizing its use in the manner detailed herein.
3. Distribution of funds to any application is at the sole discretion of The L.Y.N. Fund, Inc. and its Board of Directors.

I HAVE CAREFULLY READ, CLEARLY UNDERSTAND AND VOLUNTARILY ACKNOWLEDGE THE INFORMATION SET FORTH IN THIS RELEASE FORM. I UNDERSTAND THAT THIS FORM PROVIDES THE L.Y.N. FUND, INC. WITH MY ABSOLUTE AND UNCONDITIONAL CONSENT, WAIVER AND RELEASE OF LIABILITY, ALLOWING THE L.Y.N. FUND, INC. TO PUBLICIZE PRIVATE INFORMATION ABOUT ME. BY SIGNING THIS RELEASE FORM, I UNDERSTAND IT HAS NO BEARING ON ANY DECISIONS MADE BY THE QUALIFICATIONS COMMITTEE REGARDING FINANCIAL ASSISTANCE.

Date: _____

Applicant Name: _____

Signature: _____

Address: _____

Witness Name: _____

Signature: _____

Address: _____

Please send COMPLETED APPLICATION (all 7 pages), plus any supplemental information requested or that the applicant would like The LYN Fund to consider as part of their request should be sent by:

- **mail to: The LYN Fund, P.O. Box 2019, Palm Harbor, FL 34682 OR**
- **email to: Info@theLYNfund.org**

The LYN Fund will review all applications and be in touch if additional information is required to present your application to its Advisory Board for approval. Application for Financial Assistance are presented and reviewed monthly and you will be notified of your final application status usually within thirty (30) days of receipt.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164).

1) AUTHORIZATION:
I_____(*PRINT NAME*) authorize _____
_____ (*YOUR TREATING PHYSICIAN)* to disclose the protected health information described below to The L.Y.N. Fund, Inc.

2) EFFECTIVE PERIOD
This authorization for release of information covers the period of healthcare from_____ (*DATE*) to and through_____ (*DATE*).

3) EXTENT OF AUTHORIZATION
I authorize the release of my health record only as it pertains to my cancer diagnosis and treatment.

4) This medical information may be used by The L.Y.N. Fund, Inc. for the purpose of evaluating my eligibility for financial aid according to their guidelines or for other purposes as I may direct.

5) This authorization shall be in force and effect until _____ (*DATE*), at which time this authorization expires.

6) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

7) I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:

_____ _____
Signature Date

_____
Please Print Name