

## **COCA Cares Financial Assistance Program**

### **Our Assistance Program:**

The Colorado Ovarian Cancer Alliance is dedicated to raising awareness about ovarian cancer and supporting women with an ovarian cancer diagnosis. With this effort in mind, we have created a small financial assistance fund to help women diagnosed with ovarian cancer who find themselves in a situation of critical financial need due to the hardship of their cancer diagnosis.

Grants may be given to qualified applicants for:

- Monthly financial assistance for expenses like rent, mortgage, medical insurance premiums, groceries, childcare, transportation, utilities and medical bills. Maximum \$500/month/up to six months.
- Medical expense assistance associated with seeing a Gynecologic Oncologist for a first-time or second opinion visit. \$500 maximum.
- Limited transportation assistance to join a clinical research drug trial. \$500 maximum.
- **The COCA.Cares program pays bills and does not award funds directly to individuals.**
- Lifetime assistance limit total of \$4,000 per person.

The Colorado Ovarian Cancer Alliance grants assistance at its sole discretion. We review each application individually and speak with each applicant personally. Submission of an application is not a guarantee of assistance.

### **To Qualify for Assistance:**

We offer financial assistance to ovarian cancer patients if the applicant meets the residency, medical and financial qualifications listed below. We will also consider applicants with a fallopian tube cancer diagnosis.

#### **Residency:**

1. Must be a resident of the State of Colorado.
2. A copy of a valid Colorado ID is required.

#### **Medical:**

1. **Monthly Assistance.** To qualify for monthly assistance you must:
  - a. be diagnosed with ovarian cancer or fallopian tube cancer.
  - b. currently be in chemotherapy or other oncologist-directed treatment for ovarian cancer
  - c. **OR** have completed surgery or treatment for ovarian cancer within the last three months
  - d. provide verification of your medical status from your oncologist (see application).
2. **Medical Assistance.** To qualify for assistance with the cost of a visit to a Gynecologic Oncologist, you must:
  - a. be diagnosed with ovarian cancer
  - b. have no health insurance
  - c. **OR** have health insurance that will not cover the cost of a first time or second opinion visit
  - d. provide verification of your medical status from your current doctor (see application).
3. **Clinical Trial Assistance.** To qualify for clinical trial transportation assistance you must:
  - a. be diagnosed with ovarian cancer
  - b. provide medical verification from the clinical trial doctor (see application).

#### **Financial:**

1. **Income.** Your monthly household expenses must be more than your monthly household income, and your total income must be equal to or less than 300% of the HHS Federal Poverty Level (see attached). In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your county ([www.huduser.org](http://www.huduser.org)).
2. **Assets.** Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.
3. **Assistance in paying mortgage.** A copy of your current year's property tax is required for mortgage assistance, and that total is less than the median home sales price for your county.

**You may be asked to provide additional paperwork to COCA in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, COCA has the right to withdraw your application, stop all assistance and take steps to recover previous awards.**

For other financial assistance options, please see:  
[www.colo-ovariancancer.org/financial-resources](http://www.colo-ovariancancer.org/financial-resources)

## Follow the steps below to apply for assistance.

- Step 1:** Fill out the COCA.Cares Application pages 1 – 4. Use the Federal Poverty Level attachment to check your income level for eligibility (equal to or less than 300% FPL for your family size).
- Step 2:** Detach the COCA.Cares Medical Verification form (page 5). Take to your Oncologist's office. Have them fill it out and make a copy using their letterhead. Return to COCA by mail, email or fax.
- Step 3:** Make a copy of your current Colorado Driver's License or Colorado-issued I.D. with an address matching your application, and include with your application.
- Step 4:** Mail your completed application and all required attachments to:

**Colorado Ovarian Cancer Alliance**  
**1777 S. Bellaire St., Suite 170**  
**Denver, CO 80222**  
**attn: COCA.Cares**

**\*\*For quicker processing, you may fax the application first before sending it by mail: fax 1-866-517-0215. The original document, however, must be received before assistance can be granted.**

**Please be sure to provide all the information requested here.  
An incomplete application will delay our ability to provide you with assistance.**

Once COCA receives your application, Jeanene Smith, our COCA.Cares Program Administrator, will forward the application and any additional information to the COCA Financial Assistance Committee for a decision. Once a decision is made, an Agreement or Decline letter will be sent to you by mail. If your application has been accepted, you will be contacted to determine how to proceed with bill payment. This is also a time to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact:

**Jeanene Smith**  
**COCA.Cares Program Administrator**  
**Phone: 720-971-9436**  
**Fax: 1-866-517-0215**  
**email: [jeanene@colo-ovariancancer.org](mailto:jeanene@colo-ovariancancer.org)**

Name: \_\_\_\_\_



**COCACares**  
Financial Assistance Program

SPANISH SPEAKER

## Application – page 1 – Personal Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Colorado County \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: Home \_\_\_\_\_ Mobile \_\_\_\_\_ Work \_\_\_\_\_

Email address \_\_\_\_\_

Best way to reach you: *circle one* Home Phone Cell Phone Work Phone Email  
Best time to reach you: *circle one* Morning Afternoon Evening Best hours \_\_\_\_\_

Marital Status: *circle one* Single Married Partnered Separated Divorced Widowed

Additional Contact Person Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have health insurance? Yes  No

If yes, please indicate type of insurance (check all that apply):

Private insurance  Medicare  Medicaid  VA program  Other

If private insurance, please name insurance company: \_\_\_\_\_

Comments: \_\_\_\_\_

Are you currently working? Yes  No  If yes, how many hours/week? \_\_\_\_\_

Were you working before your ovarian cancer diagnosis? Yes  No

Total # in household: \_\_\_\_\_ # of wage-earners in home: \_\_\_\_\_ #of dependents: \_\_\_\_\_

How did you hear about the COCA.Cares program? \_\_\_\_\_

Name of person who referred you: \_\_\_\_\_

Referring person's telephone: \_\_\_\_\_ Email: \_\_\_\_\_

## Application – page 2 – Income Information

What is the total of your current **monthly** household income after taxes? Please list details below.

**TOTAL CURRENT MONTHLY INCOME:** \$ \_\_\_\_\_ **total**

### INCOME

#### Income from Wages

Your wages after payroll taxes	\$ _____
Spouse or partner's wages after payroll taxes	\$ _____
Other income from wages or self-employment	\$ _____

#### Income from Benefits & Insurance

Employer Disability Insurance	\$ _____
Unemployment Insurance	\$ _____
Retirement / Pension	\$ _____
401K / IRA Income	\$ _____
Social Security	\$ _____
SSI / SSDI	\$ _____
Other Benefits/Insurance	\$ _____

#### Income from Assistance

Alimony / Child Support Received	\$ _____
Low-Income Energy Assistance Program (LEAP)	\$ _____
Food Stamps (SNAP)	\$ _____
Temporary Aid to Needy Families (TANF)	\$ _____
Aid to the Needy and Disabled (AND)	\$ _____
Section 8 from HUD (housing supplement)	\$ _____
Help from family members	\$ _____
Help from religious / faith community	\$ _____
Help from friends	\$ _____
Help from other nonprofit organizations	\$ _____
Other Assistance	\$ _____

### **ASSETS**

Cash / Checking Value: _____	\$ _____
Savings Value: _____	\$ _____
Life Insurance Value: _____	\$ _____
Investments Value: _____	\$ _____
Retirement Funds Value: _____	\$ _____
Other Assets Value: _____	\$ _____
Real Estate Value: _____ (not the house you live in)	\$ _____

### Monthly Income

### Monthly Income From

Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.

## Application – page 3 – Expenses Information

What is the total of your current *monthly* household expenses? Please list details below.

**TOTAL CURRENT MONTHLY EXPENSES:** \$ \_\_\_\_\_ **total**

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### EXPENSES

	Monthly Expense
<b>Household Expenses</b>	
Rent	\$ _____
Mortgage	\$ _____
Energy Bill	\$ _____
Water Bill	\$ _____
TV / Internet / Cable / Satellite	\$ _____
Telephone / cell including long distance	\$ _____
Food	\$ _____
<b>Dependant Expenses</b>	
Child Care	\$ _____
Child support paid	\$ _____
Elder Care	\$ _____
<b>Transportation Expenses</b>	
Car Payment	\$ _____
Gasoline	\$ _____
Car insurance	\$ _____
Parking / Public Transportation	\$ _____
<b>Medical Expenses</b>	
Health insurance premiums	\$ _____
Medicals costs (after insurance)	\$ _____
Medication costs (after insurance)	\$ _____
<b>Loan Expenses</b>	
Loan payments	\$ _____
Credit card payments	\$ _____
<b>Other Expenses</b>	
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____

Are you currently seeking any assistance or debt relief for outstanding expense payments? Please explain.

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## Application – page 4 – Additional Information

### OVARIAN CANCER HISTORY

Date Diagnosed: \_\_\_\_\_ Stage: \_\_\_\_\_

Have you experienced a recurrence? Yes  No

Have you seen a Gynecologic Oncologist? Yes  No

Have you participated in a clinical trial? Yes  No

Surgeon: \_\_\_\_\_

Oncologist: \_\_\_\_\_

Social Worker/ Nurse: \_\_\_\_\_

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#### Please check your reason for applying for COCA.Cares assistance:

- To help with expenses while in treatment for ovarian cancer
- To help with expenses while recovering from surgery or treatment for ovarian cancer
- To see a Gynecologic Oncologist for the first time or for a second opinion
- To cover transportation costs associated with clinical research drug trial treatment

#### Read and check the boxes to verify the following information:

- I have read Page 1 and understand how and who COCA helps with financial assistance.
- I live in the State of Colorado.
- I am currently undergoing chemotherapy or other oncologist-directed treatment for ovarian cancer or fallopian tube cancer.
- I am currently within three months of ovarian cancer-related surgery, chemotherapy, or oncologist-directed treatment.
- I have signed the bottom of this page, which serves as a medical release giving COCA permission to obtain the necessary medical information to process my application.
- I understand that COCA will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview

*I understand that Colorado Ovarian Cancer Alliance (COCA) provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release COCA from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize COCA to release any information including my name, address, and type of assistance provided to any other social service agency at COCA's discretion. I also authorize the release of any medical information and documentation required by COCA for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.*

Applicant's  
Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Healthcare Provider:**

Please copy this form onto your official office letterhead, complete it and mail, fax or scan/email to:  
Colorado Ovarian Cancer Alliance – COCA.Cares Program  
1777 S. Bellaire St., Suite 170, Denver, CO 80222  
attn: COCA.Cares  
Fax: 1-866-517-0215 ~ Email: Jeanene@colo-ovariancancer.org

**COCA.Cares Medical Verification**

Date \_\_\_\_\_

Patient Name: \_\_\_\_\_

Confirmed Diagnosis: \_\_\_\_\_ Date Initial diagnosis: \_\_\_\_\_

Stage: \_\_\_\_\_ Cell Type: \_\_\_\_\_ Grade: \_\_\_\_\_

Patient is currently seeing a Gynecologic Oncologist. Yes  No  Name: \_\_\_\_\_

Patient is currently seeing a Medical Oncologist. Yes  No  Name: \_\_\_\_\_

Patient is currently being treated for a recurrence. Yes  No  Recurrence Date: \_\_\_\_\_

Patient is currently undergoing chemotherapy. Yes  No

Chemotherapy Start Date: \_\_\_\_\_ Anticipated End Date: \_\_\_\_\_

Drug: \_\_\_\_\_

Drug: \_\_\_\_\_

Drug: \_\_\_\_\_

Patient has undergone surgery. Yes  No  Most Recent Surgery Date: \_\_\_\_\_

Patient has a planned surgery. Yes  No  Planned Surgery Date: \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_

Patient is being admitted to a clinical drug trial. Yes  No

Clinical Trial Start Date: \_\_\_\_\_ Anticipated End Date: \_\_\_\_\_

Other planned treatment(s) or other important medical information about this patient's ovarian cancer treatment.

\_\_\_\_\_

Referring professional completing this form: (Physician, PA, Nurse or medical LCSW):

Name & Credentials: \_\_\_\_\_

Hospital/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Email: \_\_\_\_\_

**My signature below affirms the diagnosis and treatment information as described on this page.**

|                                  |       |
|----------------------------------|-------|
| Referring Professional Signature | Date: |
|----------------------------------|-------|

|                      |       |
|----------------------|-------|
| Oncologist Signature | Date: |
|----------------------|-------|

*Foundation For Health Coverage Education*

## 2019 Federal Poverty Level Guidelines

The benefit levels of many low-income assistance programs are based on these poverty guidelines. Find your family size and monthly or yearly income below to determine your FPL percentage category.

Note: Pregnant women count as two people for the purpose of this chart.

### 48 Contiguous States and the District of Columbia

#### ANNUAL INCOME:

| Size of family unit | 100% of Poverty | 150% of Poverty | 200% of Poverty | 300% of Poverty |
|---------------------|-----------------|-----------------|-----------------|-----------------|
| 1                   | \$12,140        | \$18,210        | \$24,280        | <b>\$36,420</b> |
| 2                   | \$16,460        | \$24,690        | \$32,920        | <b>\$49,380</b> |
| 3                   | \$20,780        | \$31,170        | \$41,560        | <b>\$72,340</b> |
| 4                   | \$25,100        | \$37,650        | \$50,200        | <b>\$75,300</b> |
| 5                   | \$29,420        | \$44,130        | \$58,840        | <b>\$88,260</b> |

#### MONTHLY INCOME:

| Size of family unit | 100% of Poverty | 150% of Poverty | 200% of Poverty | 300% of Poverty |
|---------------------|-----------------|-----------------|-----------------|-----------------|
| 1                   | \$1,012         | \$1,517         | \$2,023         | <b>\$3,035</b>  |
| 2                   | \$1,372         | \$2,057         | \$2,743         | <b>\$4,115</b>  |
| 3                   | \$1,732         | \$2,597         | \$3,360         | <b>\$5,195</b>  |
| 4                   | \$2,092         | \$3,137         | \$4,183         | <b>\$6,275</b>  |
| 5                   | \$2,452         | \$3,677         | \$4,903         | <b>\$7,355</b>  |