OVERVIEW OF FINANCIAL ASSISTANCE

(Keep this page for your records)

TOUCH INC. (TOUCH) provides non-medical financial assistance for a cancer patient if the applicant meets our criteria explained below under "Who We Can Help". TOUCH does not pay medical expenses, but we do help with everyday expenses such as transportation, utilities, child care, housing such as mortgage or rent, and other out-of-pocket expenses that are non-medical but are unable to be paid by the patient as a result of the cancer diagnosis. We DO NOT pay credit card bills. Each application is given careful, individual consideration, but TOUCH does not guarantee assistance to anyone. All awards are made at the sole discretion of TOUCH.

TOUCH has limited financial resources and will not be able to meet all your financial needs while you are undergoing treatment. We strongly encourage you to explore all other options for assistance during your treatment.

Who We Can Help

SERVICE AREAS: The areas served by TOUCH are those residents of Vanderburgh and Warrick counties in the state of Indiana. A driver's license or a copy of an apartment lease or bill with your name and address to verify resident status may be required. Depending on available resources and specific cases, TOUCH may decide to broaden this service area as needed/able.

MEDICAL: Your need for financial assistance must be related to your cancer diagnosis and treatment. To qualify for assistance you must have been diagnosed with cancer within the previous six months, or currently undergoing medical treatments for the cancer. *Federal HIPPA regulations require that TOUCH obtain your permission in writing to discuss your case with anyone else. TOUCH will need diagnosis and treatment information from your medical provider and must have proof of your consent to obtain this information.*

FINANCIAL:

1. **Income.** Your total household income from all sources including wages, government assistance, and retirement funds *(if you are already retired)* at the time of application must be less than 300% of the current Federal Poverty Level Guidelines.

2. **Assets.** Your cash or liquid assets (i.e., CDs, stocks, mutual funds) must be less than your estimated expenses for the duration of treatment. *TOUCH does not require you to get rid of your primary residence, vehicle, or personal items to qualify for assistance from us. We may, however, disqualify you from receiving assistance or reduce the amount of assistance we offer, if you have liquid assets that could be used to pay your expenses.*

IMPORTANT NOTICE: TOUCH may verify any information submitted. If you provide incorrect or misleading information on your application, on additional materials, or in any verbal communication with TOUCH personnel, TOUCH reserves the right to immediately suspend any and all current and future funding and recover all such amounts.

How Much We Can Help

The amount of support we provide for each individual may vary depending on need and TOUCH's resources. We have a fixed monthly limit of $250 and a limit of 12 months of assistance (months can be non-consecutive). This amount is not guaranteed and the **patient must call each month** in order to verify that there is still a need for assistance.

How We Can Help

Checks will be paid directly to the vendor, not the cancer patient, and TOUCH may require a written statement or verification from the vendor of the amount due. The cancer patient should not have to pay any income tax on the help provided by TOUCH.

APPLICATION DIRECTIONS

(Keep this page for your records)

TOUCH inc.

1. Use the following checklist to help you determine your eligibility.

❑ YES ❑ NO	I understand that TOUCH does not pay for medical expenses or credit card bills of any kind.
❑ YES ❑ NO	I live in Vanderburgh or Warrick County.
❑ YES ❑ NO	I am currently a cancer patient diagnosed within six months of today's date, or I am currently undergoing cancer treatments.

2. Complete the TOUCH Application

THE APPLICATION SHOULD BE FILLED OUT COMPLETELY AND ACCURATELY. An incomplete and/or inaccurate form will delay review of your application and could result in being declined for the program.

- ❑ I have signed the top of the completed Physician Form included with the application that serves as a medical release, allowing my doctor's office to share medical information needed to process my application with TOUCH.
- ❑ I understand that TOUCH will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or personal interview.
- ❑ I have signed the liability clause at the end of the personal information section in the application.

3. Gather your documents

THE FOLLOWING DOCUMENTS MUST BE RETURNED WITH YOUR APPLICATION:

1. PROOF OF RESIDENCY: You must provide proof of your physical address to verify the address provided on the application form. Acceptable documents include:

- A copy of your Driver's License or other government issued ID showing the address listed on the application
- A copy a bill, pay stub or bank statement showing the address listed on the application

2. MEDICAL STATUS VERIFICATION: Submit the completed and signed Physician Form from your oncologist/physician verifying your current diagnosis and treatment plan.

4. Return your completed application and required documents to TOUCH:

BY MAIL **TOUCH INC.**
904 S. JAMES BLVD.
EVANSVILLE, IN 47714

OR, BY EMAIL **CONTACT@TOUCHINDIANA.ORG**

APPLICATION FOR FINANCIAL ASSISTANCE

TOUCH inc.

Section 1: Personal Information

Full Name: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

Street Address (Must match your ID): _____

City: _____ ST: _____ ZIP: _____

Home phone: _____ Cell: _____ Work: _____

Best phone number to reach you: ❑ Home ❑ Cell ❑ Work Best time to call: _____

Marital status: ❑ Single ❑ Married ❑ Divorced/Separated

Additional Contact Information

TOUCH INC may discuss my application with the additional people below if we can't reach you directly.

1. Full Name: _____

   Phone: _____ Relationship: ❑ Spouse ❑ Parent ❑ Child ❑ Other _____

2. Full Name: _____

   Phone: _____ Relationship: ❑ Spouse ❑ Parent ❑ Child ❑ Other _____

Insurance Information

Health Insurance: ❑ None ❑ Medicaid ❑ Medicare ❑ Private ❑ Other

Insurance Carrier: _____

Insurance provided through: ❑ My employment ❑ Spouse's employment ❑ Other

Employment Information

Employment status BEFORE your cancer diagnosis:
❑ Full-time ❑ Part-time ❑ On Leave ❑ Self-employed ❑ Retired ❑ Unemployed

Employment status AFTER your cancer diagnosis:
❑ Full-time ❑ Part-time ❑ On Leave ❑ Self-employed ❑ Retired ❑ Unemployed

Place of last employment: _____

Date of last employment: _____

TOUCH INC. OFFICE USE ONLY – DO NOT WRITE IN THIS SECTION					
Date Received	Application Approved Yes No	Date Approved	Review Date 1	Review Date 2	Review Date 3

APPLICATION FOR FINANCIAL ASSISTANCE

TOUCH inc.

Section 2: Monthly Household Income and Current Assets

Total # of People in Household: _____ # Wage Earners in Home: _____ # Dependents: _____

MONTHLY Income Sources	BEFORE Diagnosis	AFTER Diagnosis
Your employment		
Other employment (Spouse/Partner/Other)		
Social Security		
SSI/SSDI		
Employer Disability Insurance		
Unemployment Insurance		
Retirement/Pension/401K/IRA/ Old Age Pension (OAP)		
Alimony		
Other Investment Income		
Other: _____		
MONTHLY TOTAL INCOME:		

Are you currently enrolled in any of the following programs?

1. Low-Income Energy Assistance Program (LEAP) ❑ No ❑ Yes
2. Supplemental Nutritional Assistance Program (SNAP) ❑ No ❑ Yes
3. HUD Section 8 / Other Housing Supplement ❑ No ❑ Yes
4. Temporary Aid to Needy Families (TANF) ❑ No ❑ Yes
5. Aid to the Needy and Disabled (AND) ❑ No ❑ Yes

Additional Liquid Assets	Asset Total
Cash/Checking Account	
Savings Account	
Life Insurance (Cash value)	
Investments	
Retirement Funds (If not currently retired)	
TOTAL ASSETS:	

APPLICATION FOR FINANCIAL ASSISTANCE

TOUCH inc.

Section 3: Monthly Household Expenses

NON-MEDICAL Expense Type		Estimated Expense (Monthly)
Transportation	Car Payment	
	Gasoline	
	Auto Insurance	
	Taxi/Other transportation fees	
Other	Groceries	
	Storage Fees	
	Other:	
Utilities	Electricity/Gas	
	Water	
	Sewer	
	Phone	
	Other:	
Child Care	Day care/baby sitter/ other	
Housing	Rent/Mortgage	
	Home/Renters Insurance	
	Other:	

MEDICAL Expenses NOT covered by Insurance	Estimated Expense (Monthly)
Copays/Coinsurance/Deductible Payments	
Monthly Premiums	
MONTHLY TOTAL ESTIMATED EXPENSE:	

Section 4: Signature & Acknowledgment

I understand that any award is made at the sole discretion of TOUCH INC. I release TOUCH INC. of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize the release of my name, address, and medical information or other documentation required by TOUCH INC. for the purpose of verifying this application.

Printed Name: _____ Signature _____

Date: _____

APPLICATION FOR FINANCIAL ASSISTANCE

TOUCH inc.

Section 4: Request for Medical Information / Patient Release

Instructions for the Patient

Sign your name below and deliver this form to your doctor.

I hereby consent for Dr. _____ to provide the information requested below to TOUCH INC. I understand that this information will be kept confidential and is important for the consideration of my application.

Patient Signature _____
(Parent or legal guardian if patient is a minor)

Date: _____

Instructions for the Physician

Please complete the information below to the extent possible and mail to:

TOUCH INC
904 S. St. James Blvd.
Evansville, IN 47714

Patient Full Name: _____

Specific Cancer Diagnosis: _____

Date Established: _____

Cancer treatment administered to date: _____

_____

_____

Future treatment required? ❑ Yes ❑ No If YES, Plan overview: _____

_____

Will treatment require travel outside or Vanderburgh/Warrick County? ❑ Yes ❑ No

Other comments / related expenses: _____

_____

Physician's Signature: _____

Date: _____