EDGAR J. (GUY) PARADIS CANCER FUND

GUIDELINES FOR AWARDING FINANCIAL ASSISTANCE

The **intent** of the Fund is to assure the cancer patient will have the moral support that only the presence of the family can provide when they have to travel to a medical facility outside the St. John Valley, or greater than 15 miles within the valley, for diagnostic and treatment services.

Following are the guidelines, based on the bylaws of the Fund, for determining if an applicant qualifies for assistance.

1. The patient must be diagnosed with cancer and receiving treatment or seeking further diagnostic services for the cancer. Dr. visits or treatments for other conditions are excluded.

2. The patient must be a current resident of the St. John Valley as it is described in the bylaws.

3. The applicant must be the family member or identified support person who will be accompanying the patient to his/her appointment. The check will be written to the family member or identified support person and the patient.

4. The applicant must be a current resident of the St. John Valley as it is described in the bylaws. Special consideration will be given to applicants who are family members residing outside of the Valley if the patient does not have family residing in the St. John Valley. Those applications require approval from the Board's Aid Committee.

5. Overnight stays are considered for distances beyond 100 miles **or** if the patient has treatments two days in a row and the family member or support person stays overnight with the patient in a location of less than 100 miles (i.e. Presque Isle)

6. The family member or support person must complete an application and provide verification of the appointment for which they intend to accompany the patient. A note from the doctor's office or clinic must be attached to the application. (A verification letter is provided with the application.)

7. Assistance is granted for forthcoming appointments and retroactive appointments when applications, verification, and overnight receipts are submitted within a month of the appointment.

8. The Fund is very generous in granting up to $3200 a year of financial assistance to a cancer patient's family. To assure the sustainability of the Fund, exceptions or increases are no longer possible.

9. A list of other resources will be provided to the patient and family when they do not qualify for assistance based on the intent of the fund, the bylaws, and the above guidelines. (i.e. Assistance for transportation for patients that allow family members to accompany them on that assistance. Angel flights are available for travel to Portland and Boston.)

10. Requests that do not meet the above criteria will be forwarded to the Aide Committee and they will respond to the applicant with a letter explaining the reason for the denial.

EDGAR J. (GUY) PARADIS CANCER FUND
APPLICATION FOR FINANCIAL ASSISTANCE
(For family members)

Applicant Name (Support Person):_____ Tel # _____

Patient Name: _____ Tel # _____

Address: _____

Patient's Date of Birth: _____

Relationship of applicant to the patient: __ Spouse __Domestic Partner __Parent __Sibling

___Support Person (friend, neighbor, other)

Doctor's Name: _____ Tel # _____

Location of appointment: _____

Diagnosis: _____ Date of DX _____

PLEASE FILL OUT ONLY WHAT APPLIES TO YOU

1. **ARE YOU TRAVELING OUTSIDE OF THE ST. JOHN VALLEY?**

   Where are you traveling to? _____

   Are you staying overnight? _____If so, How many nights?_____

2. **HOW WILL YOU TRAVEL?**

   By car _____ Bus _____ Other _____ Angel Flight _____

   Will your loved one be traveling with you? _____

3. **WILL YOU NEED HELP GETTING TO/FROM THE HOSPITAL FOR SERVICES?**

   How far is the hospital from where you live? _____Miles

4. **ARE YOU RECEIVING RADIATION?**

   Is your loved one receiving radiation? _____ If yes, for how many weeks? _____

   How many weeks will you be traveling with your loved one? _____

   Do you and the patient need help finding rides to the treatment? _____

5. **ADDITIONAL COMMENTS?**

   _____

   _____

   _____

CONSENT FOR AUTHORIZATION OF MEDICAL INFORMATION

I authorize Northern Maine Medical Center, its healthcare practitioners, staff and other individuals involved with the Edgar J. (Guy) Paradis Cancer Fund to receive information from my health care providers in order to assist and validate my diagnosis and dates of service so that my family may receive assistance to accompany me to my cancer treatments.

I understand that I have the right to revoke this authorization at any time. Authorization Expires: _____
(one year from today's date).

Patient Signature: _____ Date: _____

Applicant Name (Support Person): _____ Date: _____

A signed letter of verification must be attached to this application.

Every effort will be made to process your application within five (5) business days.

Mail completed application to:

Edgar J. (Guy) Paradis Cancer Fund
c/o Northern Maine Medical Center
194 East Main Street
Fort Kent, ME 04743

Or fax the application to: 207-834-2949

EDGAR J. (GUY) PARADIS CANCER FUND
VERIFICATION OF SERVICES

To: Doctor's office

From: The Aide Committee of the Guy Paradis Cancer Fund

RE: Verification of diagnosis and treatment dates

Please verify the diagnosis and dates of treatment for _____
(Patient's Name/Date of Birth)

so that the Edgar J. (Guy) Paradis Cancer Fund can provide assistance for a family member to accompany the patient to his/her diagnostic or treatment appointments so they can provide the kind of moral support that only the family can provide during this difficult time.

Diagnosis: _____

Appointment dates for the next four weeks: _____

_____

Location of appointment(s): _____

Thank you for your cooperation and assistance in helping this patient.

_____

Signature of Doctor or Office Manager Date

CONSENT FOR AUTHORIZATION OF MEDICAL INFORMATION

I authorize Northern Maine Medical Center, its healthcare practitioners, staff and other individuals involved with the Edgar J. (Guy) Paradis Cancer Fund to receive information from my health care providers in order to assist and validate my diagnosis and dates of service so that my family may receive assistance to accompany me to my cancer treatments.

I understand that I have the right to revoke this authorization at any time. Authorization Expires: _____
(one year from today's date).

Patient Signature: _____ Date: _____

Applicant Signature: _____ Date: _____

This letter of verification must be attached to the application for financial assistance.

Mail completed forms to: Edgar J. (Guy) Paradis Cancer Fund, c/o Northern Maine Medical Center, 194 East Main Street, Fort Kent, ME 04743

Or fax to: 207-834-2949