LynneKing

CANCER CARE FOUNDATION

Caring for people with cancer throughout their journey...

Assistance Application as at December 2018

Assistance Application created by the
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1. THE FOUNDATION

The Lynne King Cancer Care Foundation has been established to provide assistance to those persons with cancer who find themselves in financial difficulty or who lack an appropriate support network. We aim to assist those who suffer financial hardship as a direct result of the cost of treatments or loss of income, or both.

The Lynne King Cancer Care Foundation is a charity working to help those with cancer. However, all those associated with the foundation, including the trustees, are volunteers and receive no payment, either direct or indirect, for their services. This web site is being developed and maintained by volunteers. Such is our commitment to helping those embarking on a journey that we are all too familiar with.

The administration of The Foundation is provided by a voluntary board of trustees. Therefore **all** money raised or donated to the Lynne King Cancer Care Foundation will be used to aid those suffering the effects of cancer.

All applications will be assessed by the board of trustees.

2. WHO CAN APPLY FOR ASSISTANCE?

The Lynne King Cancer Care Foundation provides assistance to those people who require financial, emotional or medical support as a result of their cancer. Non cancer patients can not apply. A medical certificate from your GP or Specialist Oncologist will also be required.

If you have previously received assistance from either The Lynne King Cancer Care Foundation or another organisation, you are still eligible to apply.

3. WHAT TYPE OF ASSISTANCE IS AVALABLE?

The Lynne King Cancer Care Foundation seeks to support individuals affected by cancer in many ways. For example-

- The financial underwriting of more effective treatments where the financial gap places them outside of the individual's personal reach.
- Assistance to a personal carer in need of respite, by the provision of nursing care, or other supportive care during their absence.
- To assist both carers and those with cancer to access as many legitimate support organisations as possible and provide a framework in which to communicate this information to others.
- The Foundation will not give cash assistance. Instead we will make payments direct to suppliers.

The Foundation hopes to help as many of these people as funds will allow.

4. HOW DO I APPLY?

To apply for assistance from the Foundation, please fill in the attached application form. Please make sure all details are true at the time of completing the form and that your medical certificate is also attached. Carers are able to fill in the form on a patient's behalf.

5. WHERE DO I SEND THE APPLICATION?

Please send the completed application to:

THE LYNNE KING CANCER CARE FOUNDATION
PO BOX 363,
MACQUARIE PARK, NSW 1670

Or by email: info@lyncares.com

6. CONFIDENTIALITY

All applications will be treated as confidential, unless otherwise stated. In certain circumstances we may need to contact your health care professional for details of your treatment and will do so only with your permission.

7. ASSISTANCE APPLICATION FORM

A. PATIENT DETAILS

Name:

Address:

DOB:

Home Phone:

Mobile:

Email:

Do you have any of the following:

Private Health Insurance	Yes /	No
Health Care Card	Yes /	No
Pensioner Concession Card	Yes /	No
Veteran's Affairs	Yes /	No

Are you currently married or in a de-facto relationship? YES/NO

Partners name:

Partners Mobile Number:

Is your partner currently working or receiving an income? YES/NO

What is the total household income?

How many members are there in the household?

Do you have financial and/ or emotional support from your family?

Financial: YES/NO

Emotional: YES/NO

Do you have any dependents? YES/NO

If Yes, please list name and ages below:

Are you currently involved in a support group/ network? YES/ NO

If so please explain who?

If No, would you like us to put you in contact with someone? YES/ NO

SIGNATURE

I (the patient) authorise the Lynne King Cancer Care Foundation to contact my doctor to verify the details listed in the application for assistance:

_____ _____/_____/_____

Patient's Signature Date

B. APPLICANT DETAILS

Name:

Address:

Relationship to Patient:

Home Phone:

Work Phone:

Mobile:

Email:

Can we contact you for further information should we require it? YES / NO

Do you have permission from the patient to act on their behalf? YES / NO

C. WHAT ASSISTANCE DO YOU REQUIRE?

Please provide as much information about the assistance you need to help us assess your request. Please include all documentation or quotes you may have already received. Be sure to keep a copy for yourself.

Item/ Service/ Bill:

Contact Details (Supplier):

Amount:

SIGNATURE

I verify all details above to be true at the time of application.

_____ _____/_____/_____

Applicant's Signature Date

In signing this page, you are confirming that:

- You are authorised by the patient to submit this application on their behalf
- You have read the application details, terms and conditions
- All the information is true and accurate
- All sections of the application have been completed
- All relevant documentation is attached

D. HEALTH CARE WORKER VERIFICATION

This section is to be completed by the treating doctor or other member of the health care team. This must be filled in for application to be considered.

Doctor Name:

Hospital/Centre/Practice:

Address:

Work Phone:

Mobile:

Email:

How long have you been treating this patient?

Please detail the treatment this patient is currently having:

Please summarise the history of treatment:

Has the patient previously had assistance from the Lynne King Cancer Care Foundation? YES/ NO

If yes, please detail when and what the assistance was:

Has the patient (to your knowledge) had assistance previously or currently from another organisation? YES/ NO

If yes, please detail when and what the assistance is:

Please detail how you think The Lynne King Cancer Care Foundation will be able to assist this patient:

Would it be possible for a Lynne King Cancer Care Foundation representative to contact you should we require further information? YES/ NO

Please specify most convenient days and times for contact:

SIGNATURE

I verify all details above to be true at the time of application.

_____ _____/_____/_____

Doctor's Signature (or delegate) Date

(E.g. Nurse Consultant, Social Worker, Psychologist, Occupational Therapist)

In signing this page, you are confirming that:

- You are the authorised doctor (or delegate) of the abovementioned patient
- You have read the application details, terms and conditions
- All the information is true and accurate
- All sections of the application have been completed
- All relevant documentation is attached