Together in Teal
Ovarian Cancer Patient Need Fund

PROGRAM OVERVIEW

St. Louis Ovarian Cancer Awareness (SLOCA) is a 501(c3) nonprofit organization founded in 2002 to raise awareness of the signs and symptoms of ovarian cancer through various education initiatives. SLOCA also funds ovarian cancer research and provides support to ovarian cancer survivors. Through these various initiatives SLOCA has seen the financial burden that can accompany women diagnosed with ovarian cancer. To help these women in need, SLOCA has developed the *Together in Teal Fund*.

The goal of the *Together in Teal Fund* is to provide financial assistance to ovarian cancer patients so that these patients can focus on the most important thing – healing. The *Together in Teal Fund* will provide up to $1,000 annually[1] to each qualifying patient[2] to cover the following types of expenses: health insurance premiums, basic living expenses including rent/mortgage, utilities, vehicle payments and insurance, telephone and wigs. Total funds available annually will be determined by SLOCA and financial assistance may be limited by fund availability.

To be eligible, patients must be currently undergoing, or have recently completed, ovarian cancer treatment in St. Louis within the past six months. SLOCA defines "treatment" as chemotherapy, radiation, surgery, and/ or clinical trials.

PROGRAM ELIGIBILITY AND REQUIREMENTS

- Applicant must complete and supply to SLOCA an application demonstrating financial need to be qualified:
    - Applicants with annual income at or below 4.5 times the federal poverty rate will be eligible (as of 2020 for a single individual the poverty rate is $12,760 a year. For additional details see the U.S. Department of Health & Human Services Federal Poverty Guidelines.)
- Qualified applicants must present to SLOCA verifiable documentation of the eligible expenses for which the applicant is seeking financial assistance.
- Payments from the *Together in Teal Fund* will be made directly to the accounts of the eligible expenses. SLOCA cannot make payments directly to qualified applicants.
- A qualified applicant may not receive more than $1,000 annually in assistance from the *Together in Teal Fund*.
- Qualified requests will be evaluated in a timely manner; however, this should not be considered an Emergency Fund. Payments will only be made after receiving the required verifiable documentation of eligible expenses.

[1] Total funds to be issued annually to all qualified patients are limited by available budget, and shall not exceed $1,000 annually per qualified applicant.
[2] Qualified patients regardless of their sex, race, age, religion, or sexual orientation are eligible to receive funding from SLOCA.

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APPLICATION CHECKLIST

Name of Applicant:
Phone Number:

The following items must be included in your application packet. If they are not, processing may be delayed.

Financial Worksheet – including the first three pages of applicant's previous year federal tax return or other verifiable income documentation*
Signed Applicant Compliance Form
Signed authorization of Protected Health Information (PHI)
Signed and dated letter confirming diagnosis and treatment plan from a medical professional or through submission of verifiable health records.
Copies of billing statements for expenses you wish to be considered for payment.

If last year's federal tax return is not available, submit the tax return from the previous year. If tax return is not filed, submit W-2s and 1099 forms from the previous year, SSI award letter is also accepted if other documentation is not available.* ***If tax return was not filed, please check the box below.*

Check if applicable: I attest that I have not filed a federal tax return for the last two years.

Check here if you would be willing to share your story with others regarding the financial assistance you received from the *Together in Teal Fund*. Full names will not be used.

Applicant Signature: Date:

SUBMISSION INSTRUCTIONS

Please mail, or email your completed application materials to:

St. Louis Ovarian Cancer Awareness
12015 Manchester Rd. Suite 130
St. Louis, MO 63131

Email: info@sloca.org

Questions? Please call us at 314-966-7562. Applications may also be dropped off in-person but we encourage you to call to confirm staff will be in the office.

SLOCA
St. Louis Ovarian Cancer Awareness

OCRA
ovarian cancer
research alliance

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PROGRAM APPLICATION

Date of Birth: Today's Date:

Street Address: Email:

County: Occupation:

Race: Ethnicity:

Phone: Employer:

How did you hear about the Together in Teal Fund?

TREATMENT INFORMATION

Diagnosis: Stage:

Date of Diagnosis:

Proposed Treatment Summary:

Surgery:

Physician: Facility:

Procedure: Date:

Chemotherapy (Yes/ No):

Physician: Facility:

Start Date: # of Rounds:

Radiation Oncology (Yes/No):

Physician: Facility:

Start Date: # of Rounds:

Social/ Case Worker/ Nurse Navigator Name:

Phone: Facility:

Applicant Signature:

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OCRA
ovarian cancer
research alliance

TOGETHER IN TEAL FINANCIAL WORKSHEET

If prior tax returns are not available, or are not an accurate portrayal of current financial condition, complete this worksheet and submit W-2 or applicable documentation for verification. Additional documentation may be requested.

Number in Household

Household Assets

Checking Account. $

Savings Account $

Retirement Assets (e.g. 401k, IRA) $

Stocks & Bonds $

Monthly Household Income

Gross Monthly Wages $

Spouse's Monthly Income $

Additional Household Income $

Child Support $

Alimony $

Food Stamps $

SSI/SSD benefit $

Veterans benefits $

Other (Specify) $

Total Monthly Income $

Monthly Household Expenses

Rent/ Mortgage $

Home Owners/ Renters Insurance $

Cable/ Internet $

Phone(s) $)

Utilities $

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Transportation Auto Payment(s) $

Auto Insurance $

Medical Expenses

Monthly Health Insurance Premium $

Other (Specify) $

Other (Specify) $

Other (Specify) $

Other (Specify) $

Assistance Request

Please state your desired need from the following categories of eligible assistance: health insurance premiums, rent/mortgage, basic utilities (electric, gas, water, sewer, waste management), telephone, internet, car insurance, car payment, and car repair. *Bill must be in applicant's or spouse's name. Not all bills may be eligible for assistance.

Current Financial Requests (not to exceed $1,000 annually, please provide copy of bill or statement)

Example: Spire, $150

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient's Name: Patient's Date of Birth:

I hereby request that my health care provider identified below disclose the personal health information (PHI) described below to St. Louis Ovarian Cancer Awareness (SLOCA) in connection with my application for financial assistance from SLOCA.

Name of Health Care Provider:

PHI To Be Disclosed: ovarian cancer related health information

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Acknowledgment: If my medical record contains information about drug/alcohol abuse, mental health treatment, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I agree to its release. Check if you do not agree to release of sensitive information described herein:

☐ Do Not Agree

Date(s) of Service of PHI to Be Disclosed: All dates of services, unless otherwise specified below:

Revocation Right: I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the above named healthcare provider at the address stated above and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Expiration: This Authorization will expire three years from the date of my signature below, unless otherwise specified herein:

Re-Disclosure: I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.

Signature: I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization. By signing this document, I hereby authorize the above-named provider to disclose my protected health information as specified in this document.

Signature of Patient or Personal Representative:

Date:

If this Authorization is signed by the patient's personal representative, indicate such representative's authority to act on behalf of the patient:

APPLICANT INFORMATION VERIFICATION

In order to be eligible for financial assistance from the SLOCA Together in Teal Program, I agree and certify as follows:

1. I attest that the information provided in this application is complete and accurate to the best of my knowledge.
2. I understand that while every effort will be made to provide financial assistance, the Together in Teal Fund has limited funds. And as a result, I may not receive financial assistance even if I satisfy the eligibility requirements.
3. I understand the Together in Teal program eligibility criteria could be modified at any time and the Together in Teal program may be discontinued at any time.
4. I understand that SLOCA has the right to audit and confirm the accuracy of any documents or information I provide to document my eligibility and to request that I provide additional information. I understand that if I apply to receive financial assistance beyond the $1,000 annual limit, I may be required to submit updated information to SLOCA.
5. I understand that SLOCA will have the right to seek a refund of any financial assistance granted if SLOCA becomes aware that any information provided in this application is not accurate, if I do not provide any clarifying information requested by SLOCA or if I do not meet the eligibility requirements.
6. I will promptly notify SLOCA of any changes to the information I have provided to SLOCA, including financial situation, health insurance status, or medical condition.
7. I understand that I am not required to use any particular healthcare provider as a condition of receiving financial assistance under the Program and I am free to change my healthcare providers at any time.
8. I acknowledge that SLOCA may disclose certain information from my application to my health insurance carrier, ovarian cancer caregivers, pharmacists, or other parties to fulfill my request for financial assistance.
9. I understand that SLOCA aggregates data from many patients to create aggregated (summary) patient data which SLOCA may share with third parties, including researchers, partners, foundations, policy makers and other funding sources to apply for funding, prepare reports, advocate on behalf of patients, or perform other health related research.
10. I attest that I have not received financial assistance nor have I sought financial assistance for the expenses for which I am now seeking financial assistance from SLOCA. If applicable, in the event I become qualified for Medicaid coverage and in connection therewith, or otherwise, become entitled to a refund of insurance premiums that were in whole or part paid by SLOCA, I agree that SLOCA shall be entitled to receive such refunds and I will transfer any such refunds I receive to SLOCA immediately.
11. I understand that SLOCA is not an emergency fund and no payments are made automatically.
12. I understand that in no event shall SLOCA be liable in any way for damages alleged to result from errors or delays in the processing of Together in Teal program applications or the issuance

of payments as part of the Program, my choice of health care provider or the success or failure of any therapy or treatment I obtain using funds from the Program.

By signing below, I attest that I have read, fully understand, and agree to the Applicant Attestation set forth above.

Applicant's Name (Please Print):

Applicant's Signature:

Date: