5171 Glenwood Ave. Suite 401
Raleigh, NC 27612
(919) 784-0410

Patient Emergency Fund

In response to the COVID-19 pandemic and other emergencies associated with a lung cancer diagnosis, Lung Cancer Initiative (LCI) is offering the Patient Emergency Fund to provide financial support for lung cancer patients to help with healthy food costs, transportation and other non-medical expenses during uncertain times. In 2020, LCI distributed a total of $20,000 among 80 lung cancer survivors across North Carolina.

Applications may be sent to:
Mail: Colleen Christensen
5171 Glenwood Ave, Suite 401
Raleigh, NC 27612
Email: cchristensen@lungcancerinitiativenc.org
Fax: 919-784-0416

Directions to Apply

1. **All questions must be answered** in order to be considered for fulfillment.
2. Applications must have a **signature from the healthcare facility**. The **patient's signature** is optional, as we are aware many lung cancer patients are rescheduling in-person appointments and not able to physically sign.
3. One Healthcare Facility Contact may refer up to three patients in need.
4. Applications will be accepted until June 11th, 2021 and decisions will be communicated by July 2nd, 2021. All mailed applications postmarked by June 11th, 2021 will be considered.
5. After the application is processed and approved, a check for $200 will be mailed to the patient's address. Colleen will email the healthcare provider to notify when the check has been mailed.

Guidelines

1. Applicants must be a resident of North Carolina.
2. Applicants must currently be in treatment for lung cancer.
3. Please submit applications by email, mail, or fax, utilizing the contact information above.
4. LCI has budgeted to provide stipends to 50 patients across North Carolina. If more than 50 applications are received, priority will be given to patients living in the most distressed counties as indicated by NC Commerce's County Distress Rankings and the patient's demonstrated need.

Patient Emergency Fund Application

Applicant Full Name:____ Date:_______________

Address:____ Date of Birth:________

____ County of Residence:_________

Home Phone Number:____

Cell Phone Number:____

Email address:____

☐ Please check this box if you would like to opt-out from Lung Cancer Initiative emails.

1.) Please, specify your ethnicity.

□ Hispanic/Latino	□ Not Hispanic/Latino

2.) Please, specify your race. (Please check all that apply)

□ Native American	□ Native Hawaiian/Other Pacific Islander
□ Asian	□ White/Caucasian
□ Black or African American	□ Other: _____________________

3.) What is your total household income each year?

□ Less than $10,000	□ $30,000 to $39,999	□ $75,000 to $100,000
□ $10,000 to $19,999	□ $40,000 to $49,999	□ $100,000 or more
□ $20,000 to $29,999	□ $50,000 to $75,000	

(Please answer the following questions by checking the boxes with an X or √)

4.) Has your employment status or your caregiver's employment status changed due to your cancer diagnosis?	□ Yes	□ No	
a.) If working, have you had to reduce hours?	□ Yes	□ No	□ N/A
b.) If not currently working, did you have to take temporary leave or quit?	□ Yes	□ No	□ N/A

LUNG CANCER INITIATIVE
of North Carolina
A NETWORK OF HOPE AND ACTION

6.) Please describe your need for financial assistance at this time:

____

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7.) How did you find out about this patient emergency fund program?

□ Cancer Treatment Center	□ Primary Care Physician
□ Another Lung Cancer Patient	□ Friend or Family Member
□ Online	□ Other: ______________________

Healthcare Facility Information

Name of the facility where treatment will be received:____

Address of facility:____

Name of Physician:____

Healthcare Facility Contact Person:____

Email of Contact Person:____

Phone Number of Contact Person: ____

Diagnosis: ____

Is the patient currently enrolled in a clinical trial? □ Yes □ No

Signature of Patient (optional):____

Signature of Contact from Healthcare Facility:____