LUNG CANCER INITIATIVE
of North Carolina

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

Patient Access to Care Gas Card Program

The Lung Cancer Initiative of North Carolina offers the Patient Access to Care Gas Card Program to provide assistance to lung cancer patients while seeking treatment. The Initiative hopes this program will lessen the financial burden of patients receiving appropriate lung cancer treatment.

Dear Applicant:

Below are the guidelines to assist you with the completion of the paperwork necessary to apply for a gas card.

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

1. **All questions must be answered** in order to be considered for fulfillment.
2. Applications must have the **patient's signature** and a **signature from the healthcare facility**.
3. Once we receive the application, please allow **2 weeks** for the application to be processed and mailed.
4. The gas card will be mailed to the patient's address.

Gas Card Guidelines

1. Applicants must be a resident of North Carolina.
2. Applicants must currently be in treatment for lung cancer.
3. Applicants may apply once every four months to receive a $50.00 gas card.
4. **Each time an applicant applies, a new application must be filled out.**
5. For 2021, a limit of 125 gas cards will be allotted **every quarter**. If we run out for that period, your healthcare facility contact person will be notified.

Lung Cancer Initiative Access to Care Gas Card Application

Name of Applicant:_____ Date:_____

Address:_____ Date of Birth:_____

_____ Already received a gas card: Yes/No

Phone Number:_____ If yes, how long ago:_____

Email address (required):_____

1.) What is your total household income each year? (Please circle)

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	

2.) Please, specify your ethnicity. (Please check)

□ Hispanic/Latino	□ Not Hispanic/Latino

3.) Please, specify your race. (Please circle all that apply)

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

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

4.) Are you currently working while undergoing treatment?	□ 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
5.) Have you ever missed treatment due to transportation difficulties?	□ Yes	□ No	

6.) Please describe your need for travel assistance:

_____

_____

_____

_____

Lung Cancer Initiative Access to Care Gas Card Application

7.) How did you find out about the gas card program? (Please circle)

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

8.) Which of the following gift cards would you prefer?

BP	Exxon Mobil
Uber (Rideshare)	

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: _____

Treatment Information

Please estimate the number of miles roundtrip to treatment within the next **90 days** using the calculation below:

_____X _____ = _____
(Miles roundtrip for 1 trip) X (# of trips to treatment) = (Anticipated miles for 90 days)

Type of Treatment: _____

Duration of Treatment: _____

Diagnosis: _____

Is the patient currently enrolled in a clinical trial? (please circle one) Yes No

Signature of Patient:_____

Signature of Contact from Healthcare Facility:_____