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@lungcancerinitiaticnc.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)

<table>
<thead>
<tr>
<th>Less than $10,000</th>
<th>$30,000 to $39,999</th>
<th>$75,000 to $100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000 to $19,999</td>
<td>$40,000 to $49,999</td>
<td>$100,000 or more</td>
</tr>
<tr>
<td>$20,000 to $29,999</td>
<td>$50,000 to $75,000</td>
<td></td>
</tr>
</tbody>
</table>

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

- □ Hispanic/Latino
- □ Not Hispanic/Latino

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

<table>
<thead>
<tr>
<th>Native American</th>
<th>Native Hawaiian/Other Pacific Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>White/Caucasian</td>
</tr>
<tr>
<td>Black or African American</td>
<td>Other: __________________________</td>
</tr>
</tbody>
</table>

(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)

<table>
<thead>
<tr>
<th>Cancer Treatment Center</th>
<th>Primary Care Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Another Lung Cancer Patient</td>
<td>Friend or Family Member</td>
</tr>
<tr>
<td>Online</td>
<td>Other: ____________________</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>BP</th>
<th>Exxon Mobil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uber (Rideshare)</td>
<td></td>
</tr>
</tbody>
</table>

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: __________________________________________________________________________