colorado ovarian cancer alliance
www.colo-ovariancancer.org

Colorado Ovarian Cancer Alliance (COCA)
8801 E Hampden Ave., Suite 104, Denver, CO 80231
attn: COCA Cares
phone 303-588-2826 ~ toll free 1.800.428.0642 ~ fax 1.866.532-6001

COCACares Financial Assistance Program

Our Assistance Program:

The Colorado Ovarian Cancer Alliance is dedicated to raising awareness about ovarian cancer and supporting women with an ovarian cancer diagnosis. With this effort in mind, we have created a small financial assistance fund to help women diagnosed with ovarian cancer who find themselves in a situation of critical financial need due to the hardship of their cancer diagnosis.

Grants may be given to qualified applicants for:

- Monthly financial assistance for expenses like rent, mortgage, medical insurance premiums, groceries, childcare, transportation, utilities and medical bills. Maximum $500/month/up to six months.
- Medical expense assistance associated with seeing a Gynecologic Oncologist for a first-time or second opinion visit. $500 maximum.
- Limited transportation assistance to join a clinical research drug trial. $500 maximum.
- **The COCA.Cares program pays bills and does not award funds directly to individuals.**
- Lifetime assistance limit total of $4,000 per person.

The Colorado Ovarian Cancer Alliance grants assistance at its sole discretion. We review each application individually and speak with each applicant personally. Submission of an application is not a guarantee of assistance.

To Qualify for Assistance:

We offer financial assistance to ovarian cancer patients if the applicant meets the residency, medical and financial qualifications listed below. We will also consider applicants with a fallopian tube cancer diagnosis.

Residency:

1. Must be a resident of the State of Colorado.

Medical:

1. **Monthly Assistance**. To qualify for monthly assistance, you must:
    a. be diagnosed with ovarian cancer or fallopian tube cancer.
    b. currently be in chemotherapy or other oncologist-directed treatment for ovarian cancer
    c. **OR** have completed surgery or treatment for ovarian cancer within the last three months
    d. provide verification of your medical status from your oncologist (see application).
2. **Medical Assistance.** To qualify for assistance with the cost of a visit to a Gynecologic Oncologist, you must:
    a. be diagnosed with ovarian cancer
    b. have no health insurance
    c. **OR** have health insurance that will not cover the cost of a first time or second opinion visit
    d. provide verification of your medical status from your current doctor (see application).
3. **Clinical Trial Assistance**. To qualify for clinical trial transportation assistance, you must:
    a. be diagnosed with ovarian cancer
    b. provide medical verification from the clinical trial doctor (see application).

Financial:

1. **Income.** Your monthly household expenses must be more than your monthly household income, and your total income must be equal to or less than 300% of the HHS Federal Poverty Level (see attached). In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your County (www.huduser.org).
2. **Assets.** Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.
3. **Assistance in paying mortgage.** A copy of your current year's property tax is required for mortgage assistance, and that total is less than the median home sales price for your county.

You may be asked to provide additional paperwork to COCA in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, COCA has the right to withdraw your application, stop all assistance and take steps to recover previous awards.

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For other financial assistance options, please see:
www.colo-ovariancancer.org/financial-resources

Follow the steps below to apply for assistance.

Step 1: Fill out the COCA.Cares Application pages 1 – 4. Use the Federal Poverty Level attachment to check your income level for eligibility (equal to or less than 300% FPL for your family size).

Step 2: Take the COCA.Cares Medical Verification form (page 5) to your Oncologist's office. Have them fill it out and make a copy using their letterhead. Return to COCA by mail, email or fax.

Step 3: Make a legible copy of your current I.D. with an address that matches your application and include with your application.

Step 4: Mail your completed application and all required attachments to:

Colorado Ovarian Cancer Alliance
8801 E. Hampden Ave., Suite 104
Denver, CO 80231
attn: COCA.Cares

**For quicker processing, you may fax the application first before sending it by mail: fax 1-866-517-0215.
The original document, however, must be received before assistance can be granted.

Please be sure to provide all the information requested here.
An incomplete application will delay our ability to provide you with assistance.

Once COCA receives your application, Shelly Warnsholz, our COCA Cares Program Administrator, will forward the application and any additional information to the COCA Financial Assistance Committee for a decision. Once a decision is made, an Agreement or Decline letter will be sent to you by mail. If your application has been accepted, you will be told to send bills directly to the COCA Cares Program Administrator. Please feel free to connect with her to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact:

Shelly Warnsholz
COCA Cares Program Administrator
Phone: 303-588-2826
Fax: 1-866-532-6001
email: shelly@colo-ovariancancer.org

[___] SPANISH SPEAKER

Name:_____

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Application – page 1 – Personal Information

Last Name_____First Name_____Middle Initial_____

Address_____

City, State, Zip_____

Colorado County_____ Date of Birth:_____

Phone: Home _____Mobile_____ Work _____

Email address_____

Best way to reach you: *circle one* Home Phone Cell Phone Work Phone Email
Best time to reach you: *circle one* Morning Afternoon Evening Best hours_____

Marital Status: *circle one* Single Married Partnered Separated Divorced Widowed

Additional Contact Person Name:_____

Relationship:_____Phone:_____

INSURANCE: Do you have health insurance? Yes ☐ No ☐

If yes, please indicate type of insurance (check all that apply):
☐ Private insurance ☐ Medicare ☐ Medicaid ☐ VA program ☐ Other

If private insurance, please name insurance company:_____

EMPLOYMENT: Are you currently working? Yes ☐ No ☐ If yes, how many hours/week? _____

Were you working before your ovarian cancer diagnosis? Yes ☐ No ☐

Total # in household:_____ # of wage-earners in home:_____#of dependents:_____

How did you hear about the COCA.Cares program?_____

Name of person who referred you:_____

Referring person's telephone:_____Email:_____

Name:_____

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Application – page 2 – Income Information

What is the total of your current ***monthly*** **FAMILY / HOUSEHOLD income** after taxes?

TOTAL CURRENT MONTHLY INCOME: $_____ **total**

INCOME	**Monthly Income**
Income from Wages	
Your wages after payroll taxes	$_____
Spouse or partner's wages after payroll taxes	$_____
Other income from wages or self-employment	$_____
Income from Benefits & Insurance	
Employer Disability Insurance	$_____
Unemployment Insurance	$_____
Retirement / Pension	$_____
401K / IRA Income	$_____
Social Security	$_____
SSI / SSDI	$_____
Other Benefits/Insurance	$_____
Income from Assistance	
Alimony / Child Support Received	$_____
Low-Income Energy Assistance Program (LEAP)	$_____
Food Stamps (SNAP)	$_____
Temporary Aid to Needy Families (TANF)	$_____
Aid to the Needy and Disabled (AND)	$_____
Section 8 from HUD (housing supplement)	$_____
Help from family members	$_____
Help from religious / faith community	$_____
Help from friends	$_____
Help from other nonprofit organizations	$_____
Other Assistance	$_____

ASSETS	**Monthly Income From**
Cash / Checking Value:_____	$_____
Savings Value:_____	$_____
Life Insurance Value:_____	$_____
Investments Value:_____	$_____
Retirement Funds Value:_____	$_____
Other Assets Value:_____	$_____
Real Estate Value:_____ (not the house you live in)	$_____

Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.

Name:_____

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Application – page 3 – Expenses Information

What is the total of your current ***monthly*** **FAMILY / HOUSEHOLD** expenses?

TOTAL CURRENT MONTHLY EXPENSES: $_____ **total**

EXPENSES

	Monthly Expense
Household Expenses	
Rent	$_____
Mortgage	$_____
Energy Bill	$_____
Water Bill	$_____
TV / Internet / Cable / Satellite	$_____
Telephone / cell including long distance	$_____
Food	$_____
Dependant Expenses	
Child Care	$_____
Child support paid	$_____
Elder Care	$_____
Transportation Expenses	
Car Payment	$_____
Gasoline	$_____
Car insurance	$_____
Parking / Public Transportation	$_____
Medical Expenses	
Health insurance premiums	$_____
Medical costs (after insurance)	$_____
Medication costs (after insurance)	$_____
Loan Expenses	
Loan payments	$_____
Credit card payments	$_____
Other Expenses	
Other:_____	$_____
Other:_____	$_____
Other:_____	$_____
Other:_____	$_____

Are you currently seeking any assistance or debt relief fc Name:_____

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Application – page 4 – Additional Information

OVARIAN CANCER HISTORY

Date Diagnosed:______________________________ Stage:______________

Have you experienced a recurrence? Yes ☐ No ☐

Have you seen a Gynecologic Oncologist? Yes ☐ No ☐

Have you participated in a clinical trial? Yes ☐ No ☐

Surgeon:____

Oncologist: ____

Social Worker/ Nurse:____

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Please check your reason for applying for COCA Cares assistance:

- ☐ To help with expenses while in treatment for ovarian cancer
- ☐ To help with expenses while recovering from surgery or treatment for ovarian cancer
- ☐ To see a Gynecologic Oncologist for the first time or for a second opinion
- ☐ To cover transportation costs associated with clinical research drug trial treatment

Read and check the boxes to verify the following information:

- ☐ I have read Page 1 and understand how and who COCA helps with financial assistance.
- ☐ I live in the State of Colorado.
- ☐ I am currently undergoing chemotherapy or other oncologist-directed treatment for ovarian cancer or fallopian tube cancer.
- ☐ I am currently within three months of ovarian cancer-related surgery, chemotherapy, or oncologist-directed treatment.
- ☐ I have signed the bottom of this page, which serves as a medical release giving COCA permission to obtain the necessary medical information to process my application.
- ☐ I understand that COCA will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview

I understand that Colorado Ovarian Cancer Alliance (COCA) provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release COCA from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize COCA to release any information including my name, address, and type of assistance provided to any other social service agency at COCA's discretion. I also authorize the release of any medical information and documentation required by COCA for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.

Applicant's
Signature_______________________________________Date:_____________________

Print Name:____
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Healthcare Provider:
Please copy this form onto your official office letterhead, complete it and mail, fax or scan/email to:
Colorado Ovarian Cancer Alliance – COCA Cares Program
8801 E. Hampden Ave., Suite 104, Denver, CO 80231
attn: COCA.Cares
Fax: 1-866-532-6001 ~ Email: Shelly@colo-ovariancancer.org

COCA Cares Medical Verification

Date_____

Patient Name:_____

Confirmed Diagnosis:_____Date Initial diagnosis:_____

Stage:_____Cell Type:_____Grade:_____

Patient is currently seeing a Gynecologic Oncologist. Yes ☐ No ☐ Name:_____

Patient is currently seeing a Medical Oncologist. Yes ☐ No ☐ Name:_____

Patient is currently being treated for a recurrence. Yes ☐ No ☐ Recurrence Date:_____

Patient is currently undergoing chemotherapy. Yes ☐ No ☐

Chemotherapy Start Date:_____ Anticipated End Date:_____
Drug:_____
Drug:_____
Drug:_____

Patient has undergone surgery. Yes ☐ No ☐ Most Recent Surgery Date:_____
Patient has a planned surgery. Yes ☐ No ☐ Planned Surgery Date:_____

Surgical Procedure:_____

Patient is being admitted to a clinical drug trial. Yes ☐ No ☐

Clinical Trial Start Date:_____Anticipated End Date:_____

Other planned treatment(s) or other important medical information about this patient's ovarian cancer treatment.

_____

_____

Referring professional completing this form: (Physician, PA, Nurse or medical LCSW):

Name & Credentials:_____

Hospital/Clinic:_____

Address:_____

City:_____State:_____Zip:_____

Phone: (_____)_____Email:_____

My signature below affirms the diagnosis and treatment information as described on this page.	
Referring Professional Signature	Date:
Oncologist Signature	Date:

2023 Federal Poverty Level Guidelines

The benefit levels of many low-income assistance programs are based on these poverty guidelines. Find your family size and monthly or yearly income below to determine your FPL percentage category.

ANNUAL INCOME:

Size of family unit	100% of Poverty	150% of Poverty	200% of Poverty	300% of Poverty
1	$14,580	$21,870	$29,160	**$43,740**
2	$19,720	$29,580	$39,440	**$59,160**
3	$24,860	$37,290	$49,720	**$74,580**
4	$30,000	$45,000	$60,000	**$90,000**
5	$35,140	$52,710	$70,280	**$105,420**

MONTHLY INCOME:

Size of family unit	100% of Poverty	150% of Poverty	200% of Poverty	300% of Poverty
1	$1,215	$1,823	$2,430	**$3,645**
2	$1,643	$2,465	$3,287	**$4,930**
3	$2,072	$3,108	$4,143	**$6215**
4	$2,500	$3,750	$5,000	**$7,500**
5	$2,928	$4,393	$5,857	**$8,785**