January 2026

Dear Applicant,

Thank you for your interest in the Alabama Oncology Foundation's (AOF) Patient Financial Assistance Program. AOF is a 501(c)(3) charitable organization whose mission is to *Help Oncology Patients Excel* during their fight against cancer.

Enclosed is the AOF application for financial assistance. Please note that all applications must be submitted to AOF **by a referring professional**—such as your doctor, nurse, social worker, patient navigator, or another healthcare professional involved in your care.

Kindly read the instructions carefully and complete all sections of the application. Be sure to list all current expenses and provide complete income information, as this helps AOF gain a full understanding of your financial situation. Additionally, please include copies of the bill(s) you would like the Foundation to consider for payment, as well as proof-of-income documentation.

Referring professionals may submit a completed application by mail or email to:

Alabama Oncology Foundation
2550 Acton Road, Suite 150
Birmingham, AL 35243

OR
Email: *catherine.frey@alabamaoncology.com*

Thank you again for your interest in the Alabama Oncology Foundation. If you have any questions regarding the application process, please call **(205) 443-5781** or email **catherine.frey@alabamaoncology.com**.

Sincerely,
Catherine Frey
Executive Director
Alabama Oncology Foundation

Alabama Oncology Foundation

Patient Financial Assistance Program ("PFAP")

Applicants must meet the following eligibility criteria to be considered for the PFAP.

- Be a current Alabama resident and at least 18 years old.
- Have a cancer diagnosis as certified by healthcare provider or in post op care for a cancer related surgery.
- Have household income less than or equal to 200% of the 2024 Federal Poverty Limits (see below).
- Must be able to provide proof of income and bank statements for each person in household over 18 years.

200% of Federal Poverty Guidelines

# OF PEOPLE IN THE HOME	MONTHLY INCOME	ANNUAL INCOME
1	$2,510	$30,120
2	$3,407	$40,880
3	$4,303	$51,640
4	$5,200	$62,400
5	$6,097	$73,160
6	$6,993	$83,920
7	$7,890	$94,680
8	$8,787	$105,440
Each Additional Person	$897	$10,760

Source: US Dept. of Health and Human Services
https://aspe.hhs.gov/poverty-guidelines

Required income documentation:

- If employed, must provide paystubs from the last two months or a statement from employer.
- If receiving income other than wages, please provide one of the following:
  - Bank statements from the last two months
  - Social Security benefit letter
  - Social Security 1099
  - Copy of Social Security check
- If a patient is receiving no income, please provide a letter stating the reason for no income.

- Report liquid assets** totaling less than:
  - $7,500 (single individual)
  - $12,000 (family)

- List other agencies or sources from which you have requested funding if any.
- If applicable, provide denial letter from Alabama Medicaid.

**** Liquid Assets include:**
1. Checking Accounts and/or cash
2. Savings/Money Market Accounts
3. Stocks/Bonds
4. CDs
5. Mutual Funds/Taxable Annuities

** **Does not include**:
1. Equity in Primary residence
2. Value of automobiles
3. Retirement Accounts
4. Educational Accounts
5. Personal Possessions

PFAP Guidelines:

- Financial aid will be awarded to assist with the following expenses (as applicable):
    - Rent/Mortgage payments
    - Utilities: gas, power, water/sewer, propane
    - Phone (landline or cellular)
    - Health Insurance Premiums (COBRA included)
    - Office visit, surgery, or service copays
    - Prescription copays
    - Groceries
    - Transportation: gas cards (*$100 limit per gas card*), ridesharing service, medical transport, bus passes
    - Other expenses (*evaluated on a case-by-case basis*)
- All bills must be in the patient's name
- Patients must receive care in the following counties: Jefferson, Shelby or St.Clair.
- Payments will be made directly to company/creditor that is owed. Applicants must supply copies of the bill, late notice, mortgage statement, lease agreement and payment address and phone number.
- Applicants may request up to **$1,000.00** per year.
- Applicants may reapply for financial assistance on the first business day of the following calendar year if they remain eligible.
- Applicants must be referred by a physician, physician assistant, nurse, social worker, patient account representative, patient navigator or financial counselor.
- No identifying patient information that is provided voluntarily on the required application will be used by The Alabama Oncology Foundation for any purpose other than to approve assistance requests.
- Only completed applications will be considered; a complete application includes the application form, supporting proof of income documentation, the referring professional payment request form, and copies of all necessary patient bills to be paid.
- **The Alabama Oncology Foundation will assist all eligible patients in need of financial assistance on a first-come, first-serve basis to the extent funding is available.**

Alabama Oncology Foundation

Patient Financial Assistance Program Application

All requests for funding must be presented in writing using this form.
Please include any other supporting documents.

Date of Application:_____ Patient ID: _____

First name: _____ Last name: _____

Last Four Digits of Social Security #_____(not required) Birth Date_____

Check one of the following: □ Single □ Married □ Divorced □ Widowed □ Separated

Number of person(s) living in household dependent on income:_____

Ethnicity: □ Asian □ African American □ Hispanic □ Native American □ White □ Other

Address: _____

City/State/Zip:_____ County: _____

Phone Number:_____ Email: _____

Emergency Contact:_____ Phone Number: _____

What type of cancer do you have?_____ Date of Diagnosis: _____

Are you currently receiving treatment?_____Who is your oncologist? _____

Where are you receiving treatment?_____

Who is your referring professional?_____

Amount Requested: _____

Have you ever received financial assistance from The Alabama Oncology Foundation before? □ Yes □ No

What do you need assistance with? _____

_____

List other agencies you have contacted for help and when:_____

_____

Complete the following chart with the patient's income, expenses, and resources.

Monthly Household Gross Income		**Monthly Household Expenses**		**Household Assets**	
Cash	$	Rent/Mortgage	$	Checking	$
Wages (pre-deductions)	$	Utilities	$	Savings	$
Social Security	$	Groceries/Food	$	Money Market	$
Disability	$	Transportation	$	Stocks/Bonds	$
Unemployment	$	Car Payment	$	CDs	$
Retirement/ Pension	$	Out of Pocket Medical Expenses	$	Mutual Funds/ Taxable Annuities	$
Other	$	Other Expenses	$	Other	$
Total	$	**Total**	$	**Total**	$

All information I have provided is true and accurate. I understand that any financial assistance provided by the AOFis provided directly to my creditors, is limited, and is based on the immediate needs that negatively impact my health status. I understand this application will expire six months from date of the submission. Providing false information will result in denial of assistance.

I authorize the AOF to contact my health care provider(s) listed above, and I authorize my health care provider(s) to release information to the AOF related to this application*. If requested by my health care provider(s), I will complete an appropriate authorization to allow him/her to release information to the AOF pertaining to this application. All information provided to the AOF will remain confidential, except that the AOF may discloseinformation to my creditors and others as may be necessary to provide financial assistance.*

I fully understand that AOF's funds to provide assistance may be limited and that I should coordinate a plan for long term financial support by contacting additional community resources.

I understand that although the AOF may consider billing cycles and due dates when providing financial assistance,I remain fully responsible for timely payments of my debts, and I will indemnify and hold harmless the AOF for anyexpenses, losses, or liabilities arising from or related to my debts.

_____ _____

Applicant's Signature **Date**

Referring Professional Payment Request Form Date of Request:_____

To be completed by referring professional; this form accompanies the application form.

Patient Name:_____ **DOB:** _____

Please pick the category that best describes how this request benefits the individual **(***check all that apply to the bills submitted <u>today</u>***).**

	Rent/Mortgage payments		**Groceries**
	Utility bills (gas, power, water/sewer, propane)		**Transportation costs:** **$100 gas card (one per month) _____** **Ridesharing service _____** **Medical Transport _____** **Bus Pass _____**
	Phone bills (landline or cellular)		
	Health Insurance premiums [COBRA included]		
	Office visit, surgery, or service copays		**Other Expenses (please describe):** **_____** **_____** **_____**
	Prescription copays		

Bill Name, Address, Phone (required)	Account #	Amount Requested
		$
		$
		$
		$
		$
	Total request **(max $1,000)**	$

Attach bills to support each request except if requesting a gas card.

Please provide any additional information that may assist AOF in making payment arrangements:

_____

_____

I reviewed this application and I agree with the funding need.

_____ _____

Referring professional -Print Name & Date Referring professional -Signature

Organization: _____

Phone:_____ Fax:_____

<u>Please email this form to Catherine Frey at catherine.frey@alabamaoncology.com</u>