The Incyte Cancer Care Assistance Fund for Delaware

The Incyte Cancer Care Assistance Fund for Delaware is an emergency fund that was established by Incyte Corporation for the purpose of providing emergency financial assistance to people with cancer who both reside in Delaware, and are U. S. citizens. This fund is administered by Cancer Support Community Delaware and is available to cancer patients who demonstrate financial need, who are in active treatment or have recently received treatment for cancer.

The fund may provide for basic living expenses and/or medical expenses for eligible cancer patients. Expenses considered include, but are not limited to, rent, mortgage, utilities, medical bills, co-pays, scans, and testing.

Guidelines:

- Applicants **must reside in Delaware and be U. S. citizens**, regardless of where they are receiving treatment.
- Applicants must demonstrate **a clear financial hardship** during and up to one year after treatment, and the inability to pay for current living expenses and/or medical bills.
- The application form must be **filled out completely**. (if questions do not apply, please write "N/A")
- **Confirmation of a cancer diagnosis** and treatment must be provided by a physician, or other medical professional on the applicant's medical team.
- **Payments will be made directly to service providers** – no funds will be given directly to patients or their families.
- Applicants may re-apply after 3 months and are required to complete the addendum (last page of this application) and provide updated/current bills.
- Applicants may apply for assistance a **maximum of TWO times**.
- The maximum combined total an applicant may receive is $3,000.

The Incyte Cancer Care Assistance Fund for Delaware

Application Addendum

This page must be completed when **re-applying** for funds.
Please provide copies of current/updated bills.
Applicants may re-apply after 3 months, and the maximum combined total an applicant may receive is $3,000.

Name: ____________________________ Date of Birth: _____/____/______
Address:____
____
____
Home phone: ___________________ Cell phone: ___________________
Email address: ______________________________
Today's date: _____/_____/______
Date previously applied: _____/_____/______
Amount previously awarded: _______________

UPDATED PERSONAL STATEMENT

Please update us on your cancer diagnosis and current treatment.

____
____
____
____
____
____
____
____
____

Please provide an updated statement on your financial situation and how your cancer diagnosis and treatment has caused you financial hardship.

____
____
____
____
____
____
____

EXPENSES

List all expenses you are asking for assistance with **and provide legible copy of bill(s) you wish to be paid. Bills must show the payment coupon, your total name and address, total due, and total name and address of payee.** Screen shot of a current bill in not acceptable, it must be an invoice. The maximum combined total an applicant may receive is $3,000.

TYPE	PROVIDER/COMPANY	AMOUNT DUE	DATE DUE
Rent/mortgage:	________________	___________	_________
Electric:	_________________	___________	_________
Gas/oil:	_________________	___________	_________
Phone/internet:	________________	___________	_________
Cell phone:	_________________	___________	_________
Other:	_________________	___________	_________
	_________________	___________	_________
	_________________	___________	_________
Medical:	_________________	___________	_________
	_________________	___________	_________
	_________________	___________	_________
	_________________	___________	_________

Signature of applicant: ______________________________Date: ___/___/_____

Cancer Support Community Delaware
4810 Lancaster Pike Wilmington, DE 19807
Phone: (302) 995-2850 Fax: (302) 995-0834
npickles@cscde.org