Joseph Michael Chubbuck Foundation (EIN 46-3739937)

PO BOX 4917 ROME, NY 13442

2026 Financial Assistance Application & Consent Form

The JMCF provides financial assistance with out-of-pocket expenses not covered by insurance. Such as: utility & phone bills, rent, gas, groceries, lodging, cabs & bus fare, and medically necessary equipment/supplies**. The JMCF DOES NOT PROVIDE ASSISTANCE FOR MEDICAL BILLS, CO-PAYS, OR NON-TRADITIONAL MEDICINES & FOOD SUPPLEMENTS (SUCH AS HERBS, ETC.).**

TO QUALIFY FOR ASSISTANCE: The patient must be in "active treatment" *(currently receiving chemo, radiation, targeted therapy, or having cancer surgery at time of application's submission & processing) AND the patient must live in or be receiving treatment in Oneida, Herkimer, Madison, or Onondaga Counties in Central New York State.*

APPLICATION SUBMISSION: ***The application requires (2) signatures***: the patient or legal guardian's & the treating oncologist/radiologist, oncology LSW, or treatment center's designee, *not general office staff*). **If either of these signatures are missing, then the application WILL NOT be processed.**

These signature(s) give the JMCF permission to call/*email the submitting physician's office, oncology LSW, or treatment center's designee to verify that the patient is currently in active treatment for cancer (to ensure the appropriate use of donated funds).*

TREATMENT CONFIRMATION: Once the application has been completed & has BOTH required signatures, pages 2 & 3 must be sent to the JMCF for processing to begin. These pages can be scanned and emailed to contact@thejmcf.org, faxed to 315-339-5993, or mailed to JMCF PO Box 4917 Rome, NY 13442. *If you have questions or concerns, please call 315-339-5993 (M-F, 9am to 5pm). If you are having difficulties with faxing, please call the office as well.*

ASSISTANCE ALLOCATED: Once the application has been submitted with required signatures and the patient's treatment status has been verified; the amount of assistance to be allocated will be determined. The amount allocated may differ from what the patient had requested; based upon current funds available, demand upon the JMCF, and Board approval. Patients can receive up to $400/calendar year *(this total includes any funds given for gas assistance*). More assistance can be requested from the JMCF in emergency and/or other carefully reviewed situations.
Gas cards will be given to patients for gas assistance (*maximum per calendar year is $200)*. Gift cards to major grocery store chains will be given to patients requesting grocery assistance. Pre-paid credit cards may also be issued for gas/grocery assistance. Assistance for needed medical equipment/supplies will be sent directly to the vendor. Gift cards to major drug stores OR Amazon may be requested by the patient for supply/equipment needs OR the patient can provide receipts to the JMCF for reimbursement. Bank check or JMCF check will be sent to landlord for rent AND utility companies & phone companies for utility assistance. Patients in need of transport assistance will have a prepaid credit card mailed to them to use for tickets, cab fare, or UBER Or the JMCF will pay the provider directly. THE JMCF may issue foundation checks to assist patients upon careful review of the circumstances. **Note:** *the amount of assistance awarded will be based upon funds available at the time of the application's processing & the level of patient demand on the JMCF at the time of processing. The JMCF is not responsible for lost or stolen gift card(s) or check once the card(s)/check has been placed in the mail & posted to the address provided on the application.*

2026 JMCF Application for Assistance

Please Circle the Area(s) below that you are seeking Financial Assistance with.
List amount requested & attach needed documentation *(where indicated)*

****Be sure to Email, Mail, or Fax REQUIRED Documents along with the application or processing cannot take place****

Utility Bill(s) – FAX, Email, or Mail a copy of the bill(s) along with your Application
(Foundation cap is $400 - see JMCF mailing address, Fax Number, and Email address on page 1)

Grocery – circle the store(s) you could accept a Grocery Card from:

Walmart *Hannaford* *Price Chopper*
Amount Requested *$*_____
**Max $400 (Max of $200 if gas assistance is also being requested)*

Rent –total amount of monthly rent _____*(Foundation will cap at $400)*
Month/Date rental assistance is needed: _____
Check one : Individual Landlord _____ or Corporation _____
Landlord name _____ Phone # (___)_____
Address _____

Gas Assistance – circle station(s) you can accept a Gas Card from:

Stewarts *Circle K* *Speedway* *Byrne Dairy*
Amount Requested _____ $50, $75 $100 (Max is $200/year)

Hotel Expenses –you must attach your receipt of payment to the hotel for reimbursement.

Cab/Bus/UBER Services – attach quote of cost from service provider you will be using- **along with Date(s) needed**. *JMCF will pay the service provider directly, reimburse the patient (with proof of prior payment) or purchase an online UBER gift card (to be mailed to the patient, LSW, or treatment center designee).*

Provider:_____ Total Cost _____
Dates needed: _____

Medical Supplies/Equipment- attach quote, doctor's script or contact information for JMCF direct purchasing.

Drug Store Purchase or Gift Card Request

Drug Store Name _____
Item(s) _____
Cost _____ **(if seeking reimbursement attach receipt of purchase).**

Amazon Purchase or Gift Card Request (attach quote for JMCF purchase)

Item(s) _____
Cost _____ **(if seeking reimbursement attach receipt of purchase).**

OTHER AREAS OF NEED ***(List need & attach any needed quote/bills or receipts of payment):***

_____

_____

PLEASE PRINT NEATLY & SIGN 2 REQUIRED CONSENT AREAS

Date financial assistance is needed by _____
Name of Treatment Facility _____
Physician's Name at Facility _____
Physician's Address _____
_____
_____

Phone ( ) _____ Fax ( ) _____

Required *** Signature Required of Oncologist/Radiologist, Oncology LSW, or Designee**

Signature_____ ***Date*** _____

Your signature confirms this patient is **CURRENTLY IN** ***active treatment –"chemo, radiation, targeted therapy, cancer surgery" (not in remission, not under observation, not on hormone prevention treatment).***

Patient Name (print neatly) _____
Address: _____
_____

Patient's Date of Birth _____
Patient's Phone Number (____)_____

Required *Patient Signature (or legal guardian if under 21 or not able to sign)
Signature _____***Date*** _____

NO APPLICATION WILL BE PROCESSED WITHOUT THE PATIENT'S SIGNATURE ***(LEGAL GUARDIAN IF UNDER 21 OR NOT ABLE TO SIGN)*** **& THE TREATING ONCOLOGIST/RADIOLOGIST (oncology LSW or treatment center designee) SIGNATURE. GENERAL OFFICE STAFF CAN NOT SIGN THIS APPLICATION UNLESS APPROVED TO DO SO. No application will be processed without the** ***REQUIRED DOCUMENTATION*** ***(WHERE INDICATED).*** ***Patient signature or guardian signature gives JMCF permission to contact the treating physician's office or*** *LSW to confirm treatment status.* The JMCF does not discriminate based on race, color, religion, sex, national origin, disability, or age. Informational Resources – To learn more about resources that may you, please go to the www.thejmcf.org and click on "RESOURCES". Amount allocated will be based upon funds available and demand for assistance at the time of processing.