Ovarian Cancer Alliance of Ohio | 4900 Reed Road | Suite #311 | Columbus, Ohio 43220 | 614.546.9498 |

Financial Aid Program

The Ovarian Cancer Alliance of Ohio (OCAO)'s Financial Aid Program is dedicated to supporting women across Ohio diagnosed with ovarian cancer. The Program is specifically aimed to help local women with expenses during and after cancer treatment.

Grants may be given to qualified applicants in the form of gift cards for the amount of $500 per year to be used for:

- Food
- Gasoline for cars

Lifetime assistance $2000 per person. Yearly assistance $500 per person.

Ovarian Cancer Alliance of Ohio grants assistance at its sole discretion. We review each application individually. Submission of an application is not a guarantee of assistance.

Assistance Qualifications:

We offer financial assistance to ovarian cancer patients who meet the **residency**, and **medical** qualifications listed below.

Residency:

You must be a resident of Ohio. Proof of residency is required with the application.

Medical:

You must be diagnosed with ovarian cancer, and currently be in chemotherapy or other oncologist-directed treatment for ovarian cancer OR have completed surgery or treatment for ovarian cancer within the last three months. You must provide verification of your medical status from your oncologist (see application).

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

Follow these steps below to apply for assistance.

Step 1: Fill out the OCAO Application pages

Step 2: Detach the OCAO Medical Verification form. Request your oncologist to fill out the Verification form.

Step 3: Make a copy of your current Ohio Driver's License, Ohio-issued I.D, or other proof of residency with an address matching your application and include it with your application.

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

Ovarian Cancer Alliance of Ohio
Attn: Kelli Merb
4900 Reed Rd Suite 331
Columbus Ohio 43220
Or email to financialaid@ocao.org

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The OCAO financial aid committee will review your application upon receipt. Once a decision is made, an 'Acceptance' or 'Declination' letter will be sent to you by mail or email. If your application has been accepted, you will be contacted to determine how to proceed with dispersion of gift cards. This is also a time to ask questions and clarify any issues. All applications will be processed in a timely manner. For questions, please contact: OCAO at 614-546-9498 or FinancialAid@OCAO.org

Personal Information

Last Name_____ First Name _____Middle Initial_____

Address_____City_____State_____

Zip_____ 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_____

Additional Contact Person
Name:_____
Relationship:_____Phone:_____

How did you hear about the OCAO program? _____

Name of person who referred you: _____
Referring person's Telephone: _____Email:_____
Name: _____

OVARIAN CANCER HISTORY

Date Diagnosed: _____Type of Ovarian Cancer (if known) _____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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Read and check the lines to verify the following information:

__I have read Page 1 and understand how and who OCAO helps with financial assistance.
__I live in Ohio.
__I am currently undergoing chemotherapy or other oncologist-directed treatment for ovarian 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 Ovarian Cancer Alliance of Ohio permission to obtain the necessary medical information to process my application.
__I understand that OCAO will ask personal questions about my treatment. I agree to provide accurate answers in a telephone or in-person interview

I understand that Ovarian Cancer Alliance of Ohio (OCAO) 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 OCAO from all liabilities or claims whatsoever arising out of the donation of money. I authorize OCAO to release any information including my name, address, and type of assistance provided to any other social service agency at OCAO's discretion. I also authorize the release of any medical information and documentation required by OCAO for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required. This signed release will expire in one year from date signed.

Applicant's Signature _____Date: _____

Print Name: _____

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Healthcare Provider: Please complete the following form and mail, scan, or email it to Ovarian Cancer Alliance of Ohio.

Ovarian Cancer Alliance of Ohio – OCAO Financial Aid Program
Mail: 4900 Reed Road suite 331 Columbus Ohio 43220 Attn: Kelli Merb
Email: FinancialAid@OCAO.org

OCAO Gift 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 gynecologic 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: _____