American Cancer Society, Inc.
US Virgin Islands 2022 Financial Assistance

PROGRAM DETAILS:

The American Cancer Society US Virgin Islands Financial Assistance Program aids cancer patients via the ACS National Cancer Information Center (NCIC) and the ACS Puerto Rico Patient Service Center (PSC).

Financial assistance is provided to permanent residents of the US Virgin Islands for the following services related to cancer diagnosis: prescription drugs, labs, medical studies, cancer treatment (radiation, chemotherapy, surgery), medical equipment (medport, wheelchair, walker and other), prosthetics, bras, medical supplies (diapers, blue pads, gauzes, ostomy supplies and other) nutritional supplements (only if patient is in active treatment), lymphedema equipment, therapies and evaluation, and home assistance directly linked to cancer care.

Air and Ground Transportation assistance as follows: Air: financial assistance for airline tickets if patient needs to receive treatment, surgery of follow-up medical visits in the U.S. Besides pathology, patient must provide evidence of medical appointment in USA and air transportation receipt. Ground: financial contribution towards mileage from the patient's home to the medical facility is provided when patient is receiving radiation and chemotherapy treatment.

ELIGIBILITY:

The Financial Assistance Program is available to every insured, uninsured and ineligible for health care cancer patient who is a citizen of the United States, permanent resident of the US Virgin Islands and has physical and/or postal address in the US Virgin Islands.

PROCEDURES:

All services must be preapproved. To comply with our Confidentiality Policy, we do not receive patients in our facilities. In a call/email, our specialists will instruct the caller on the documents required to qualify for the Financial Assistance Program (Pathology report for all cancer diagnosis except for breast cancer. Medical order and quote besides pathology are required for breast cancer patients.) Once the Service Request is completed it is reviewed. When the Service Request is approved, a specialist from the Patient Service Center (PSC) will contact the patient to inform them of the approval and/or the health care provider in cases the payment is directed to them. All Financial Assistance is based on the patient's need and determined on a case by case basis. Assistance will depend on the availability of funds. To request financial assistance, the patient, caregiver or health care professional should follow one of the following steps:

- **email** puertorico.psc@cancer.org the "ACS USVI New Patient Registration Form" and supporting documentation for the request and a specialist will respond within 24-48 hours.
- **or call** the American Cancer Society Patient Service Center (PSC) in Puerto Rico **1-888-227-3201**
- **or call** the American Cancer Society toll-free number **1-800-ACS-2345** and let the specialist know that there's a special program through the American Cancer Society for USVI and ask that they look up your zip code and search for financial assistance. They may also provide you with additional cancer information and resources.

CONTACT INFORMATION:

National Cancer Information Center (NCIC)
1-800-ACS-2345 (1-800-227-2345)
Open 7 days/week; 24 hours/day
Let the NCIC specialist know that there's a special program through the American Cancer Society for USVI and ask that they look up your zip code and search for financial assistance.

Patient Service Center (PSC)
1-888-227-3201
Email: puertorico.psc@cancer.org
Open Monday – Friday; 8:30 AM – 5:00PM AST
American Cancer Society, USVI Financial Assistance
Puerto Rico Patient Service Center (PSC)
PO Box 366145
San Juan, PR 00936-6145

NEW PATIENT REGISTRATION
PROGRAM PARTICIPATION

ALL INFORMATION WILL REMAIN CONFIDENTIAL. THIS IS NOT A SOLICITATION.
(Please print clearly to limit delays with service)

Name of Patient: _____ Sex: ❒ F ❒ M

Address: _____ City: _____

State: _____ Zip Code: _____ E-mail: _____

Primary Language: _____ Date of Birth: _____ Daytime Telephone: (_____) _____
Month / Day / Year

❒Black ❒American Indian/Alaska Native ❒Asian ❒Caucasian/White ❒Hispanic/Latino ❒Pacific Islander ❒Other

Insurance Information: ❒Medicaid ❒Medicare ❒Private ❒Uninsured ❒Military Program

Insurance Name: _____ Phone: _____

Type of Income: _____ How did you find out about ACS?: _____

TYPE OF CANCER: _____ DATE OF DIAGNOSIS: _____
Month / Year

TYPE OF TREATMENT: ❒ Chemotherapy ❒ Radiation ❒ Hormone ❒ Surgery ❒ Other RECURRENCE: ❒ Yes: _____ ❒ No
Month / Year

Physician Name: _____ Phone: _____

Place of Treatment: _____ Address: _____

Start Date: _____ End Date: _____
Month / Year Month / Year

TYPE OF TREATMENT: ❒ Chemotherapy ❒ Radiation ❒ Hormone ❒ Surgery ❒ Other RECURRENCE: ❒ Yes: _____ ❒ No
Month / Year

Physician Name: _____ Phone: _____

Place of Treatment: _____ Address: _____

Start Date: _____ End Date: _____
Month / Year Month / Year

FINANCIAL ASSISTANCE:

❒ Medical Studies ❒ Prosthetics ❒ Nutritional Supplements ❒ Durable Medical Equipment

❒ Air Transportation ❒ Ground Transportation ❒ Wigs ❒ Medication ❒ Surgery

❒ Treatment ❒ Mammogram Program ❒ Other: _____

SUPPORT SERVICES & PROGRAMS

❒ Resources, Information & Guidance ❒ Reach to Recovery® *reach.cancer.org*

❒ Thank you for reviewing information on the cancer related programs and services offered by the American Cancer Society. We care about your privacy and protect how we use your information. When you fill out this form, you give us permission to use the information to better understand and meet your needs. To view the American Cancer Society's complete privacy policy or if you have any question about the Society's privacy standards, please visit www.cancer.org or call 1-800-ACS-2345.

Patient Signature: _____ Date: _____

Please email completed patient registration to:
puertorico.psc@cancer.org

The information contained in this form is legally privileged and confidential. It is intended for the use of the American Cancer Society of Puerto Rico, Inc. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this form is strictly prohibited. Please contact via email if this message was sent by error. Thanks for your cooperation.

USVI FINANCIAL ASSISTANCE PROGRAM

2022 PATIENT EXPENSE FORM

Patient Name _____ **Patient Email** _____ **Date** _____

Guardian/Caregiver Name (optional) _____

All services must be preapproved.

Subject to availability of funds, and appropriate documentation submitted, 2022 annual maximum is $800 per patient. Additional exceptions up to $1,200 will be considered on an individual basis. Priority will be given to newly diagnosed patients. Pathology report must be submitted as requested by Patient Service Representative. Additional documentation to that listed below may be required.

Payment Type:

☐ Check here to receive payment by Direct Deposit *(this option may take 1 to 2 weeks after all documentation is received, approved, and payment is processed; Account info to be collected by Patient Service Representative.)*

☐ Check here to receive payment by Mail *(this option may take 3 to 4 weeks after all documentation is received, approved, and payment is processed)*

Mailing Address: _____

Type of Service & Purpose *(please list each service/request separately)*	Date *(required for each service)*	Amount *(required for each service)*	*Documentation Needed* *(please check each box to confirm required documentation has been attached for each service)*			
Air Transportation (roundtrip or one-way for appointments related to your diagnosis)			**Quote or Receipt**	**Appointment Schedule**	**Medical Order**	**Prescription**
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
Ground Transportation (on-island or off-island appointments related to your diagnosis)			**Quote or Receipt**	**Appointment Schedule**	**Medical Order**	**Prescription**
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
		$	☐	☐	N/A	N/A
Medical Studies/Scans/MRIs/X-Rays/Labs/Other			**Quote or Receipt**	**Appointment Schedule**	**Medical Order**	**Prescription**
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A

USVI FINANCIAL ASSISTANCE PROGRAM

2022 PATIENT EXPENSE FORM

Patient Name _____ **Patient Email** _____ **Date** _____

Type of Service & Purpose *(please list each service/request separately)*	Date *(required for each service)*	Amount *(required for each service)*	*Documentation Needed* *(please check each box to confirm required documentation has been attached for each service)*			
Cancer-Related Treatments/Radiotherapy/Chemotherapy/Surgery/Other			Quote or Receipt *(if available)*	Appointment Schedule	Medical Order	Prescription
		$	☐	N/A	N/A	N/A
		$	☐	N/A	N/A	N/A
		$	☐	N/A	N/A	N/A
		$	☐	N/A	N/A	N/A
Medications/Prescriptions			Quote or Receipt	Appointment Schedule	Medical Order	Prescription
		$	☐	N/A	N/A	☐
		$	☐	N/A	N/A	☐
		$	☐	N/A	N/A	☐
		$	☐	N/A	N/A	☐
Nutritional Supplements			Quote or Receipt *(if available)*	Appointment Schedule	Medical Order *(if available)*	Prescription
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
Prosthetics/Bras/Lymphedema Sleeves/Wigs/Other			Quote or Receipt	Appointment Schedule	Medical Order	Prescription
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
Durable Medical Equipment/Medical Supplies/Other			Quote or Receipt	Appointment Schedule	Medical Order	Prescription
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
		$	☐	N/A	☐	N/A
Home Assistance/Other Services/Needs (related to your diagnosis)			Quote or Receipt	Appointment Schedule	Medical Order	Prescription
		$	☐	☐	☐	☐
		$	☐	☐	☐	☐
		$	☐	☐	☐	☐

Please email, fax, -or- mail completed Patient Expense Form along with a legible, clear picture -or- copy of documentation requested to puertorico.psc@cancer.org -or- FAX: 787-772-0090 -or- PO Box below