



## **CRITERIA FOR ELIGIBILITY OF FINANCIAL AID CONSIDERATION**

Applicant must:

Have a prostate cancer diagnosis confirmed by a licensed physician in one of the following categories:

- a) Have had a MR-guided biopsy.
- b) Have undergone alternative treatment and be a qualifying candidate for the experimental treatment with a qualified provider.

Have met the inclusion criteria for the experimental treatment using MR-Guided Focal Laser Thermal Therapy of Prostate Cancer with a qualified provider.

Be a citizen of the United States of America.

Provide a signed application, affidavit affirming financials and other documentation demonstrating financial need in accordance with the Financial Aid Benefit Table.

*Criteria for eligibility of financial aid consideration is subject to change without notice.*

**FINANCIAL AID BENEFIT TABLE**

**2022 Federal Poverty Guidelines (effective Jan. 12, 2022)**

<b>Person(s) in Household</b>	<b>Annual Income</b>	<b>Monthly Income</b>	<b>150% of Monthly Income</b>	<b>200% of Monthly Income</b>	<b>250% Monthly Income</b>	<b>300% of Monthly Income</b>
1	\$13,590	\$1,133	\$1,699	\$2,265	\$2,831	\$3,398
2	\$18,310	\$1,526	\$2,289	\$3,052	\$3,815	\$4,578
3	\$23,030	\$1,919	\$2,879	\$3,838	\$4,798	\$5,758
4	\$27,750	\$2,313	\$3,469	\$4,625	\$5,781	\$6,938
5	\$32,470	\$2,706	\$4,059	\$5,412	\$6,765	\$8,118
6	\$37,190	\$3,099	\$4,649	\$6,198	\$7,748	\$9,298
7	\$41,910	\$3,493	\$5,239	\$6,985	\$8,731	\$10,478
8	\$46,630	\$3,886	\$5,829	\$7,772	\$9,715	\$11,658

For households with more than 8 persons, add \$4,720 annually for each additional person

<b>Net Worth</b>	<b>Must be less than:</b>	<b>\$100,000</b>	<b>\$150,000</b>	<b>\$200,000</b>	<b>\$250,000</b>	<b>\$300,000</b>

Net worth is determined by your personal financial statement (Assets minus Liabilities)

<b>Liquid Cash Assets</b>	<b>Must be less than:</b>	<b>\$20,000</b>	<b>\$30,000</b>	<b>\$40,000</b>	<b>\$50,000</b>	<b>\$60,000</b>

Liquid cash is determined by available (100%) cash in accounts and one-half (50%) value of securities and life insurance cash value and one-quarter (25%) of retirement account balances.

<b>Foundation Benefit</b>		100%	95%	90%	85%	80%
<b>Your Share of Costs</b>		0%	5%	10%	15%	20%

**Signed acknowledgements for the following:**

- Conditions of Financial Aid Consideration
- Adopted Policy for Cost Capitation

**Application for Financial Aid Consideration**

- A completed and signed Application for Financial Aid Consideration
- A photo copy of your driver's license

**Copies of the following financial records:**

- Signed Tax Returns for the past two (2) years \*
  - Bank Statements for the past three (3) months
  - Retirement Account Statements for the past three (3) months
  - Investment Account Statements for the past three (3) months
  - Annuity Statements for the past three (3) months
  - Any Other Income Statements for the past three (3) months
- \* If taxes were not filed for the last two years, provide copies of all bank statements and other statements for the last six (6) months and a written explanation why taxes were not filed.

**Verification of Income for all members of the household:**

- Copies of paycheck stubs for past two (2) months
- Copies of disability check stubs for past two (2) months and approved benefit letter
- Copy of unemployment benefit letter
- Copy of social security benefits statements
- Copies of any other income receipts for past two (2) months

**Signed releases for the following:**

- Certification, Waiver and Release
- Authorization for Release of Information
- Authorization for Release of Protected Health Information (please list person(s) we may discuss your care with)



**CONDITIONS OF FINANCIAL AID CONSIDERATION**

Financial support consideration shall be determined on an individual basis based upon the client’s financial needs. If there is a percentage based share of cost due by the applicant, the applicant must pay their share of the cost directly to the provider of services before the Foundation remits payment.

Financial assistance will be paid directly to the provider of services.

Eligibility decisions are subject to review by the Board of Directors and may be accepted or rejected based upon Applicant’s financial need subject to the Foundation’s financial support criteria and that the requested MR-guided focal laser thermal therapy of prostate cancer care is from a qualifying experimental treatment provider.

Applicant understands that the Foundation may ask for a written and/or video testimonial that the Foundation, at its discretion, may use for any and all public relation purposes. While the Foundation appreciates any offered testimonials, the Applicant is not required to provide a testimonial and has the option to opt-out of said request.

Applicant understands that the Foundation may ask for a written “Thank You” letter addressed to the Foundation and/or direct benefactor(s) sharing your personal experience and comments on how the Foundation and the benefactor’s contribution has helped you. Applicant is not required to provide a written “Thank You” note, but if done, you authorize that your written letter may be shared directly with the benefactor(s).

I have read the above statement and understand that I must meet the “Criteria of Eligibility” and that I agree to fulfill the “Conditions of Participation” in order to be considered for financial aid.

\_\_\_\_\_  
Print Applicant’s Name

\_\_\_\_\_  
Applicant’s signature

\_\_\_\_\_  
Date



**ADOPTED POLICY FOR COST CAPITATION**

Contingent upon the availability of funds, The Focal Therapy Foundation's Patient Assistance Policy is as follows:

Per patient lifetime cap of \$30,000 for experimental prostate cancer treatment for MR-Guided Focal Laser Thermal Therapy of Prostate Cancer within the United States of America. The lifetime cap is reduced by an amount equal to the patient's share of cost, if any, so that the total financial benefit for the clinical trial shall not exceed a lifetime cap of \$30,000 in cancer treatment services.

A treatment plan and cost estimate will be required from the patient's medical service provider. A letter will be sent to the medical service provider stating that the patient has applied to the Foundation for financial assistance and that we are requiring a cost estimate prior to approval.

If a patient does not participate in the post-treatment conditions, then patient shall be barred from receiving any further support from the Foundation, including any retreatment, in the event such retreatment is deemed appropriate.

I have read the policy as stated above and understand the lifetime cap and conditions for financial aid.

\_\_\_\_\_  
Print Applicant's Name

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date

**APPLICATION FOR FINANCIAL AID CONSIDERATION**

Applicant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Residential Address (do not list PO Box unless homeless) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address (if different from residence) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cellular Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Social Security \_\_\_\_\_

What is/was your occupation? \_\_\_\_\_

Are you currently employed?                      Yes                      No

If yes, name of employer: \_\_\_\_\_

If no, what was your last date of employment: \_\_\_\_\_

Name of physician managing your cancer care: \_\_\_\_\_

Your physician's phone number: \_\_\_\_\_

If other dependents are living in your household check the box and fill out page 2

Have you filed tax returns over the past two years? \_\_\_\_\_  
 If no, please explain why you have not filed federal returns on page 2.

**I verify, under penalty of perjury, that all of the information provided in this application and accompanying documents are accurate and valid. I further certify that I am a citizen of the United States of America.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ e-mail address

**DEPENDENT'S LIVING AT HOME WITH APPLICANT**

	<b>Applicant's spouse, partner or significant other</b>	<b>Household Member</b>	<b>Household Member</b>	<b>Household Member</b>
First Name				
Last Name				
Date of Birth				
Relationship to Applicant				
Gender M / F				
Marital Status				
Employed Yes / No				
Name of Employer				
Disabled Yes / No				
If Disabled, Temporary Permanent				

\* Please duplicate this page if you are listing more than four (4) dependents

Additional comments:

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**FINANCIAL STATEMENT DISCLOSURE**

Name:

Social Security Number:

**ASSETS**

Cash in Bank (Schedule 1)	
Value of Stocks and Bonds (Schedule 2)	
Cash Value of Life Insurance (Schedule 3)	
Retirement Account Balance (Schedule 4)	
Money Loaned to Others (Schedule 5)	
Value of Real Estate Owned (Schedule 6)	
Value of Business (self-employed)	
Other Assets	
Other Assets	
Other Assets	
<b>TOTAL ASSETS</b>	

**LIABILITIES**

Accounts Payable	
Loan on Life Insurance (Schedule 3)	
Credit Card Balances (Schedule 7)	
Real Estate Mortgage (Schedule 6)	
Notes Payable to Banks	
Notes Payable to Others	
Other Liabilities	
Other Liabilities	
Other Liabilities	
Other Liabilities	
<b>TOTAL LIABILITIES</b>	

**COMBINED HOUSEHOLD MONTHLY INCOME**

Salary/Wages	
Pension Income	
Social Security Income	
Disability Income	
Unemployment Income	
Worker's Comp Earnings	
Alimony	
Rental Income	
Investment Income	
Other Income	
<b>TOTAL MONTHLY INCOME</b>	

**COMBINED HOUSEHOLD MONTHLY EXPENSES**

Mortgage / Rent (Schedule 6)	
Utilities	
Automobile Payments	
Transportation Costs (Gas, Insurance, Repairs)	
Food	
Medical Premiums / Prescriptions	
Alimony / Child Support	
Credit Cards - Minimum amount due (Schedule 7)	
Other Expenses	
Other Expenses	
<b>TOTAL MONTHLY EXPENSES</b>	



**FINANCIAL STATEMENT DISCLOSURE (Schedules)**

**Schedule 1 CASH (Bank Accounts)**

Name of Financial Institution	Account Number	Balance

**Schedule 2 STOCKS AND BONDS OWNED**

Number of Shares or Bond Amount	Description (Name of Company or Fund and Exchange Symbol)	For Unlisted Securities		Annual Income	Present Market Value
		Date Acquired	Cost		

**Schedule 3 LIFE INSURANCE**

Insured	Insurance Company	Beneficiary	Face Amount of Policy	Cash Value	Loan Against Policy

**Schedule 4 RETIREMENT ACCOUNT**

Name of Financial Institution	Account Number	Balance

**Schedule 5 MONEY LOANED TO OTHERS**

Name of Debtor	Date Acquired	Loan Amount	Balance Owed	Maturity Date	Payment Terms	Descripton

**Schedule 6 REAL ESTATE OWNED (HOME, INCOME PROPERTY, ETC...)**

Property Type (Primary, Rental, Vacation)	Date Acquired	Purchase Price	Current Market Value	Mortgage Lender	Mortgage Balance	Monthly Mortgage Payment





**CERTIFICATION, WAIVER AND RELEASE**

By signing below, I certify, under penalty of perjury, that the information contained in this application is true and correct and that I am a patient in need of financial assistance for medical care and treatment.

By signing below, I hereby acknowledge that The Focal Therapy Foundation, including the Board of Directors, honorary board members, members, officers, volunteers, employees, and/or agents (collectively "Foundation"), has the sole discretion in awarding or refusing to grant funds pursuant to this application for financial assistance. I further acknowledge that the Foundation is not obligated to make such discretionary financial assistance payments on my behalf. I understand and hereby acknowledge that the Foundation reserves the right to refuse or terminate any and all payments for any reasons at any time and without notice. The Foundation shall not be liable for any injury, disease, death or other harm, which may result following any termination or refusal to provide financial assistance. I also understand and acknowledge that any financial assistance provided by the Foundation to pay for medical care or treatment is not assignable and that any assignment thereof shall be void.

By signing below, I hereby acknowledge that the Foundation is not responsible for any diagnosis, selection or appointment of physicians(s) or medical care or treatment that I require. In reviewing this application, the Foundation in no way shall be deemed to have issued a diagnosis of my medical condition or to have recommended a treatment plan. Any evaluation of medical records is for the sole purpose of evaluating this application for financial assistance.

By signing below, I hereby release, waive, and discharge the Foundation from any and all liability, and further covenant not to sue the Foundation, as a result of any medical care or treatment or refusal of treatment in any way associated with this application for financial assistance or which I may receive in conjunction with any funds provided by the Foundation on my behalf. I hereby acknowledge that payments by the Foundation for medical care or treatment on my behalf will not subject the Foundation to any liability for any injuries I may receive in connection with such medical care or treatment. I expressly release the Foundation from any and all liability under any cause of action in connection with any injury, disease or death resulting from the medical care or treatment that I may receive. In the event of a dispute, the prevailing party shall be entitled to have and recover all costs and expenses, including all attorneys' fees. I expressly agree that this Certification, Waiver and Release is intended to be as broad and inclusive as is permitted by the laws of the State of California and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

By signing below, I hereby acknowledge that the Foundation operates with a finite amount of funding and may not be able to financially support initial or recurrent treatments up to the lifetime cap. I hereby release, waive, and discharge the Foundation from any and all liability in the event that funding becomes unavailable at a time when additional treatment services may be required.

I certify that I have read and voluntarily signed this Certification, Waiver and Release, and agree that no oral representations, statements or inducement apart from what is contained in this application have been made.

\_\_\_\_\_  
Print Applicant's Name

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date



**AUTHORIZATION FOR RELEASE OF INFORMATION**  
(This allows the Foundation to communicate with your medical providers.)

To Service Provider:

For the purposes of continued medical care or treatment, I hereby authorize The Focal Therapy Foundation and its representatives to discuss my Application for Financial Assistance (including, but not limited to my financial information, diagnosis and treatment) and related medical care with physicians/medical providers (and their representatives).

I also authorize the release of any medical records and information by my medical care providers to The Focal Therapy Foundation.

\_\_\_\_\_  
Print Applicant's Name

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

(This allows the Foundation to communicate with your Family and Friends. List their names below)

I hereby authorize \_\_\_\_\_

*(List names of person(s) authorized to discuss/release your health information. If left blank the Foundation may communicate with any person identifying themselves as a family member or friend communicating on your behalf)*

to obtain my information from and/or release information to The Focal Therapy Foundation.

**This authorization is for full disclosure of all health care information.**

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that this revocation will not apply to information that has already been released based upon this authorization. I understand that authorizing the disclosure of this health information is voluntary.

I do not need to sign this form to ensure treatment.

\_\_\_\_\_  
Print Applicant's Name

\_\_\_\_\_  
Applicant's signature

\_\_\_\_\_  
Date