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 laser focal therapy treatment with a qualified provider.

Have met the inclusion criteria for the 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

2024 Federal Poverty Guidelines (effective Jan. 11, 2024)

Person(s) in Household	Annual Income	Monthly Income	150% of Monthly Income	200% of Monthly Income	250% Monthly Income	300% of Monthly Income
1	$15,060	$1,255	$1,883	$2,510	$3,138	$3,765
2	$20,440	$1,703	$2,555	$3,407	$4,258	$5,110
3	$25,820	$2,152	$3,228	$4,303	$5,379	$6,455
4	$30,200	$2,600	$3,900	$5,200	$6,500	$7,800
5	$36,580	$3,048	$4,573	$6,097	$7,621	$9,145
6	$41,960	$3,497	$5,245	$6,993	$8,742	$10,490
7	$47,340	$3,945	$5,918	$7,890	$9,863	$11,835
8	$52,720	$4,393	$6,590	$8,787	$10,983	$13,180

For households with more than 8 persons, add $5,380 annually for each additional person.

Net Worth	Must be less than:	$100,000	$150,000	$200,000	$250,000	$300,000

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

Liquid Cash Assets	Must be less than:	$20,000	$30,000	$40,000	$50,000	$60,000

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.

Foundation Benefit		100%	95%	90%	85%	80%
Your Share of Costs		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
_____ AnnuityStatements 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 NA
_____ 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 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 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

The Focal Therapy™ FOUNDATION

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 currrently employed? Yes No

If yes, name of employer: _____

If no, what was your last date of emplolyement: _____

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

	Applicant's spouse, partner or significant other	Household Member	Household Member	Household Member
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 lsiting more than four (4) dependents

Additional comments:

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	
TOTAL ASSETS	

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	
TOTAL LIABILITIES	

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	
TOTAL MONTHLY INCOME	

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	
TOTAL MONTHLY EXPENSES	

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 Secuirities		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

Schedule 7 CREDIT CARD BALANCES

Financial Institution	Account Balance	Minimum Monthly Amount Due

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