Maryland Department of Health and Mental Hygiene

Maryland Cancer Fund

Grant Application Instructions for

Cancer Treatment

Fiscal Year 2008

Center for Cancer Surveillance and Control
Family Health Administration
201 W. Preston Street
Baltimore, MD 21201
410-767-0963

April, 2008
(Updated August, 2008)

Maryland Department of Health and Mental Hygiene
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Grant Application Instructions for
Cancer Treatment
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The Family Health Administration, Center for Cancer Surveillance and Control, a unit of the Department of Health and Mental Hygiene (DHMH) of the State of Maryland, hereinafter called "DHMH" is soliciting proposals from qualified applicants to pay for cancer treatment for Maryland residents. "Treatment" is defined as the medical management and care of a patient that is provided for:

(a) Cancer diagnostic testing, staging or treatment, including, including:
- (i) Surgery;
- (ii) Chemotherapy;
- (iii) Radiation therapy;
- (iv) Hormonal therapy;
- (v) Biopsy;
- (vi) Imaging procedures;
- (vii) Laboratory testing;
- (viii) Home health services; and
- (ix) Medical supplies or medical equipment;

(b) Treating medical complications resulting from cancer screening or treatment;
(c) Treating other co-morbid conditions in order to treat cancer; or
(d) Providing palliative or end-of-life care.

Background: The Maryland legislature passed House Bill 1000 in 2004 to allow Maryland taxpayers to donate money on their income tax return to the Maryland Cancer Fund (MCF). Monies donated to the MCF may be used for cancer research, prevention, early detection, and treatment and are administered by the Maryland DHMH, Center for Cancer Surveillance and Control (CCSC). This application is for eligible organizations interested in applying for funding to pay for the Maryland Health Insurance Plan (MHIP) or for direct payment of cancer treatment ("Non-MHIP") for Maryland residents, as specified in COMAR Regulations 10.14.05. Grant funding may be used to pay for MHIP premiums, deductibles, coinsurance, and copays for the months of coverage under the MHIP not to exceed 1 year and the total funds requested not to exceed $10,000 per individual patient per year. Grant funding may be used to directly pay for cancer treatment (as defined above and on page 7-8) not to exceed $20,000 per individual patient per year. For more information on MHIP, go to http://www.marylandhealthinsuranceplan.state.md.us/. For more information on the MCF, please go to http://www.fha.state.md.us/cancer/cancerfund/.

Summary Information:

Application Deadline: Open and Continuous (dependent upon the availability of funds)
Type of Grant Application: Cancer Treatment Cost Reimbursement Grant

Total Maximum Grant Award:

- If applying for funding to pay for MHIP: not to exceed $10,000 per individual patient per year for premiums, deductibles, coinsurance, copays, and applicant indirect costs.
- If applying for funding to directly pay for cancer treatment, Non-MHIP: not to exceed $20,000 per individual patient per year for treatment of cancer and applicant indirect costs.
- Indirects costs (7% for local health departments, 10% for non-local health departments) in addition to grant award amount

Award Period: 1 year

Availability of Funds: MCF funds are limited; **Before completing an application, contact the MCF Coordinator, Angel Davis** at 410-767-3117 or adavis@dhmh.state.md.us to determine if funding is available.

Anticipated Notification of Award: Within 10 days after cancer treatment grant application is received.

Eligible Organizations: Local Health Departments and other DHMH CCSC-funded cancer screening programs (for example, the local Breast and Cervical Cancer Programs, the Cigarette Restitution Fund Local Public Health Programs, the Baltimore City Centers for Disease Control and Prevention [CDC] Colorectal Cancer Screening Demonstration Program, and the MCF Cancer Early Detection/Secondary Prevention Programs). All organizations must have an office located in Maryland.

Eligible Individual Patient Needing Treatment: An individual is eligible if the individual:

- Is uninsured;
- Is a Maryland resident;
- Has a family income not more than 250% of the federal poverty guideline (for more information, please visit http://aspe.hhs.gov/poverty/08poverty.shtml); and
- Has a finding that makes the individual eligible for the treatment award no longer than 6 months prior to the date on which the MCF receives the application for treatment funds.

Effective Date of Award: The effective date of award will be:

- The date on the Standard Grant Agreement between DHMH and the Grantee.

Funding provisions:

- MCF funding **may NOT** be used to pay for cancer treatment services rendered prior to the Effective Date of Award.
- If the applicant receives Cigarette Restitution Funds (CRF) allocated for treatment of targeted cancers, those CRF funds must be exhausted or obligated before applying for MCF Treatment Grant funds.
- Applicants may request an advance payment of up to 50% of the total requested amount if applying for a confirmed cancer diagnosis (see Terms and Conditions of Grant Awards, B.2. d., page 10).

Anticipated Grant Period: One year from the date of award.

Mailing Address and for Information:
Ms. Angel Davis, MBA, MS, RN
Coordinator, Maryland Cancer Fund
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201
Phone number: 410-767-3117
E-mail address: adavis@dhmh.state.md.us

Application Submission:

Please submit 2 copies of your entire Grant Application Packet to:
Ms. Angel Davis, MBA, MS, RN
Coordinator, Maryland Cancer Fund
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201

Grant Application Packet for MCF Cancer Treatment Grant
Eligible organizations submitting a Cancer Treatment Grant Application under the MCF requirements (COMAR 10.14.05) must include the following information in the grant application packet in the order outlined below:

1. Organization Application for a Maryland Cancer Fund Cancer Treatment Grant (DHMH-4682)
2. Completed treatment application form:
   (a) Maryland Health Insurance Plan [MHIP] application http://www.marylandhealthinsuranceplan.state.md.us/mhip/html/HowtoEnroll.html, OR
   (b) Non-MHIP Cancer Treatment Application for an Individual (DHMH-4683) (including Proof of residency eligibility, and either Proof of annual family income or a notarized statement of no income (DHMH-4685)
3. Physician Letter Certification of Diagnosis with cancer or treatment for cancer, date of diagnosis or treatment, specialty, medical license number (See template.)
4. Maryland Cancer Fund Cancer Treatment Plan and Budget (DHMH-4684) (See samples.)
5. Certification for Maryland Cancer Fund Cancer Treatment Grant (DHMH-4681)
6. Completed budget pages: Applicants should complete fiscal budget forms 432 A.-H. (at http://www.dhmh.state.md.us/forms/sf_gacct.htm), as applicable, and submit DHMH hard copies with application to MCF Coordinator, and electronically as an attachment to e-mail to FHAUGA-MCF-Cancer@dhmh.state.md.us
7. If applying for cancer treatment grant for confirmed cancer diagnosis, applicants may request advance payment of up to 50% of the total requested amount (see Terms and

Conditions of Grant Awards, B.2. d., page 10). The applicant must submit DHMH fiscal budget form 437 (http://www.dhmh.state.md.us/forms/download/g_accoun/437form.pdf) hard copies with application to MCF Coordinator, and electronically as an attachment to e-mail to FHAUGA-MCF-Cancer@dhmh.state.md.us

Application Evaluation Review Criteria:

The Center for Cancer Surveillance and Control shall review each cancer treatment grant application packet based on:

1. Availability of funds;

2. Completeness of application; and

3. Whether the application for cancer treatment grant meets the relevant application process and documentation requirements set forth in this grant application packet.

Attachments

Attachment 1: Glossary for the Maryland Cancer Fund Treatment Grants

Attachment 2: Terms and Conditions of Maryland Cancer Fund Treatment Grant Awards for Local Health Departments and Other DHMH CCSC-funded Cancer Screening Program Applicants

Attachment 3: COMAR 10.14.05.14 Application Process for Cancer Treatment Grants--Maryland Cancer Fund

Attachment 1
Glossary for the Maryland Cancer Fund Treatment Grants

For the purpose of this grant the following terms are defined as:

“Annual Family Income” means the total amount received per year from all sources before taxes are withheld.

“Authorized representative” means an individual or organization that has received permission from an individual diagnosed with cancer to perform certain tasks on the individual's behalf.

“Capital expenditures” means money spent to add or expand property, equipment, and assets that will benefit an organization in the long term.

“Coinsurance” means the percent of allowable charges for a medical service that an individual with health insurance is responsible for paying.

”Copayment (copay)” means the set amount of money that an individual with health insurance is responsible for paying each time the individual receives a medical service.

“Deductible” means the amount of money that an individual with health insurance is required to pay before the individual's health insurance starts coverage.

“Department” means the Department of Health and Mental Hygiene.

“Diagnosis” is defined as a histopathologic finding of cancer in a:

a. Biopsy; or
b. Surgical specimen.

“Family” means the unit comprised of all of the following that apply:

(a) For a financially independent adult 18 years old or older diagnosed with cancer, the adult diagnosed with cancer or the adult diagnosed with cancer and one or more of the following:

(i) Spouse;

(ii) Financially dependent child; or

(iii) Financially dependent relative; or

(b) For a financially dependent child, the child and one or more of the following:

(i) Parent, foster parent, or guardian;

(ii) Sibling living in the household; or

(iii) Half brother or half sister living in the household.

"Federal poverty level" means the amount of household income by family size that a family needs for basic necessities as determined by the federal poverty guidelines, as amended, which are updated annually in the Federal Register by the U.S. Department of Health and Human Services. Please visit http://aspe.os.dhhs.gov/poverty/08poverty.shtml

"Individual" means the patient receiving cancer treatment.

"Major medical equipment" means equipment that:

(a) Costs in excess of $500; and

(b) Is used for the provision of medical or health services.

"Maryland Health Insurance Plan (MHIP)" means a State-administered program that:

(a) Is operated by a unit within the Maryland Insurance Administration under Insurance Article, Title 14, Subtitle 5, Annotated Code of Maryland; and

(b) Provides health insurance coverage to medically uninsurable Maryland residents.

"Medicaid" means the program that:

(a) Provides comprehensive medical and other health-related care for eligible individuals; and

(b) Is administered by the State under Title XIX of the Social Security Act, 42 U.S.C. §§1396—1396v.

"Medical Assistance" means the program administered by the State under Title XIX of the Social Security Act, which provides comprehensive medical and other health-related care for eligible categorically and medically needy persons.

"Medicare" means the medical insurance program administered by the federal government under Title XVIII of the Social Security Act, 42 U.S.C. §§1395—1395hhh.

"Organization" means the applicant that is applying for a cancer treatment grant on behalf of the patient. The organization is the recipient of the grant award.

"Physician" means an individual who is licensed to practice medicine in the jurisdiction in which the service is provided.

"Premium" means the amount of money than an individual pays in regular installments to a health insurer for a health insurance policy.

"Treatment" means the medical management and care of a patient that is provided for:

(a) Cancer diagnostic testing, staging or treatment, including:

(i) Surgery;
(ii) Chemotherapy;
(iii) Radiation therapy;
(iv) Hormonal therapy;
(v) Biopsy;

(vi) Imaging procedures;
(vii) Laboratory testing;
(viii) Home health services; and
(ix) Medical supplies or medical equipment;

(b) Treating medical complications resulting from cancer screening or treatment;
(c) Treating other co-morbid conditions in order to treat cancer; or
(d) Providing palliative or end-of-life care.

Attachment 2

Terms and Conditions of Maryland Cancer Fund Treatment Grant Awards for Local Health Departments and Other DHMH CCSC-funded Cancer Treatment Grant Grantees

The successful awardee ("Grantee") must comply with the following terms and conditions of grant award. Local Health Department Grantee must comply with Terms and Conditions listed in the Human Service Agreements, Conditions of Award **(**see http://www.dhmh.state.md.us/forms/download/g_accoun/2007/FY08AwardHumanSer-Final.doc), especially sections LHD General Conditions A.-B., and FHA/LHD Conditions of Award, General Conditions/Instructions for FHA, A.-C.

A. Clinical Services:

1. The Grantee shall provide the type of services indicated in their award letter/package or conditions of award.
2. The Grantee shall provide treatment payments under this grant only to an individual who is a Maryland resident, is uninsured at the time of application to the program, and has an annual family income that is not more that 250 percent of the federal poverty level.
3. The Non-MHIP Grantee if paying fee for service shall:
   a. Reimburse the provider in an amount not greater than the Medicaid rate for the medical procedure or the HSCRC-regulated rate for the medical procedure performed in an HSCRC-regulated facility; or if the applicant is a medical provider, accept the Medicaid rate as payment in full for the cancer treatment procedures provided; and
   b. Only reimburse for treatment services rendered on or after the Effective Date of Award.
4. The Grantee shall maintain a record for each individual who receives treatment services under this grant.
5. Under this grant, the Grantee shall use the treatment grant funds to:
   a. Pay up to a maximum of $10,000 per individual patient per year for the premium, deductible, coinsurance, and copay of the Maryland Health Insurance Plan (MHIP); or
   b. Pay up to a maximum of $20,000 per individual patient per year from the MCF for treatment costs detailed under a treatment plan for individuals who meet the eligibility criteria.
6. A system must be in effect to protect from inappropriate disclosure individual patient records and data collection forms created or used in connection with any activity funded under this grant.
7. The Grantee acknowledges its duty to become familiar with and fully implement all requirements of the federal Health Insurance Portability and Accountability Act (HIPAA), 4 U.S.C. § 132od et seq. and all implementing regulations including 42 CFR Part 2, 45 CFR Parts 142, 160 and 164 (compliance date April 2003) as promulgated. The Grantee also agrees to comply with the Maryland Confidentiality of Medical Records Act (MCMRA), Md. Health-General § 4-301 et seq. This obligation includes, but is not limited to adhering to the privacy and security requirements for protected health

information under federal HIPAA and state MCMRA, and otherwise providing good information management practices regarding all health information and medical records.

8. The Grantee agrees to make available their program records for inspection and audit, by the DHMH at any reasonable time, upon request. In addition, the Grantee must comply with all aspects of information and data gathering requirements as stipulated by the DHMH Audit Division's Audit Engagement Scheduling Notice.
9. The Grantee agrees to cooperate with periodic site visits by the Maryland DHMH.

B. Payments under the Grant:

1. Reimbursements to Grantees are approved only for actual expenditures.
2. The Grantee:
   a. Shall bill the Department no more than quarterly according to the schedule in Grant Award Letter.
   b. Shall send request for payment to:

Ms. Angel Davis, MBA, MS, RN
Coordinator, Maryland Cancer Fund
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, Maryland 21201
Phone number: 410-767-3117

   c. Shall bill by submitting to MCF Coordinator DHMH Form 437 (http://www.dhmh.state.md.us/forms/download/g_accoun/437form.pdf) and Form 438 (http://www.dhmh.state.md.us/forms/download/g_accoun/438form.pdf) along with attached proof of actual expenditures (for example, patient billing forms HCFA 1500, UB92, etc.);
   d. May request an advance payment of up to 50% of the total amount of the grant award at the time of application (in advance of paying bills, if applying for cancer treatment grant for confirmed cancer case) by submitting a DHMH Form 437 (http://www.dhmh.state.md.us/forms/download/g_accoun/437form.pdf). The 50% advance payment will be applied to invoices based on actual expenditures under this agreement for treatment services rendered on or after the Effective Date of Award. Subsequent payments will be based on actual expenditures reported to the extent that they exceed the initial 50% payment, and may be requested by submitting DHMH Form 437 and DHMH Form 438 (http://www.dhmh.state.md.us/forms/download/g_accoun/438form.pdf) no more than quarterly, along with attached proof of actual expenditures (patient billing forms HCFA 1500, UB92, etc.).

C. Financial Reports and Records:

1. The Grantee shall:
   a. Establish a separate account to track expenditures under the grant;
   b. Maintain accurate records, including documentation of each transaction pertaining to the grant.

2. The Grantee's request for payment (DHMH 437 and 438) and annual financial expenditure report (DHMH 440) shall include:
    a. the grant number,
    b. the time period covered in the request for payment of expenditures,
    c. the approved line item budget,
    d. line item expenditures,
    e. the complete name and billing address,
    f. the Grantee federal tax identification number, and
    g. the original signatures, in blue ink, of the requesting financial official and the contact person for the grant.
3. The Grantee shall submit to the MCF Coordinator an annual financial expenditure report DHMH **Form 440** http://www.dhmh.state.md.us/forms/download/g_accoun/2007/440form(Revised%208.7.07).pdf as specified in the Grant Award Letter:
    a. **no later than 60 calendar days after the close of the first fiscal year** in which the Grantee receives funds and,
    b. for the second fiscal year in which the Grantee receives funds, a final annual expenditure report covering the entire grant period **no later than 60 calendar days after the end of the grant period.**
4. The DHMH may audit the accounts referenced above at anytime.
5. The grantee shall submit to the Department a refund of any unexpended funds within 60 days after the termination of a grant.
6. The Grantee shall retain all records pertaining to a grant award for 3 years from the date the final financial expenditure report is submitted under Section C.3. of the Terms and Conditions of Grant Awards.
7. In the case of an audit or litigation, the Department may extend the time period under Section C.6., above, until the completion of the audit or litigation.

D. Final Report to MCF: Grantees shall send a final report to the MCF Coordinator at the time that the final DHMH Form 440 is submitted.

1. A Grantee receiving a cancer treatment grant shall include the following information in the final report for each individual for whom the Grantee is paying MHIP premiums or for whom the Grantee is receiving funds for cancer treatment:
    a. Type of cancer;
    b. Stage of cancer at diagnosis;
    c. Age;
    d. Race;
    e. Gender;
    f. County;
    g. Amount of funds expended: and
    h. Brief summary of treatment received.

E. Termination:

1. The Department may terminate a grant for the following reasons:
    a. If a Grantee fails to comply with the requirements of the award;
    b. If a Grantee fails to carry out the purposes for which the grant was awarded;

c. In compliance with a court order; or
d. At the request of the Grantee.

2. The Department and the State are not responsible for any expenses incurred by a Grantee after cancellation of a grant.
3. The Grantee shall return all unexpended funds to the Department within 60 days of termination of a grant.

F. Compliance with Existing Laws and Regulations:

The Grantee shall ensure that an activity conducted in the performance of the grant is in compliance with all state, federal, and local laws.

G. Unallowable uses of Grant Funds:

1. The Grantee agrees that this grant is the payer of last resort.
2. Grantees may not use grant money from the Fund to pay for:
    a. Major medical equipment purchases;
    b. Renovations;
    c. Capital expenditures;
    d. Insured individuals;
    e. Cancer screening, diagnosis or treatment that would be provided by an individual's existing health insurance including:
        i. Medical Assistance;
        ii. Medicare; or
        iii. Private health insurance.

Attachment 3
COMAR 10.14.05.14 Application Process for Cancer Treatment Grants
Maryland Cancer Fund

- For each applicant that plans to pay for an applicant's treatment by paying premiums through the Maryland Health Insurance Plan (MHIP), the following must be submitted:

1. A completed enrollment application form for the MHIP for each individual for whom grant money is being requested. The application must include the following:

(a) Applicant's name
(b) Phone Number
(c) Mailing Address
(d) County
(e) Signature of the applicant as the authorized representative of the individual;
Signature of the individual diagnosed with cancer if the individual is an adult;
or
Signature of the parent or guardian if the individual diagnosed with cancer is under 18 years old.

2. A letter written by the individual's physician on the physician's letterhead:

(a) Confirming that the individual has been diagnosed with or treated for cancer
(b) Confirming the dates of diagnosis or treatment
(c) The physician's full name, address, Specialty and medical license number

3. Proof of current Maryland residency for each individual for whom grant money is being requested following the guidelines listed in the enrollment applicant packet for the MHIP.

(a) Maryland driver's license or State identification card issued no fewer than 6 months prior to the application date
(b) Lease or rental agreement
(c) Property tax bill
(d) Motor vehicle registration
(e) Pay check or stub with name and home address
(f) Utility bill
(g) Voter registration card
(h) W-2 Statement issued not more than 12 months ago.

4. Proof of annual family income for each individual for whom grant money is being requested, must include:

(a) Most recent income tax return
(b) Most recent W – 2 form
(c) Two pay stubs for two consecutive pays or pays in the same month
(d) Social Security entitlement letter stating that the individual is not working and does not have any income

5. A signed application which:

(a) Certifies that the applicant shall pay the premium, deductible, coinsurance, and co-pay for the individual for whom the MHIP enrollment form is completed.
(b) Documents the following:
(i) Eligibility of the individual for funding including the number of

individuals in the family of the individual for whom the applicant is applying and the family's annual household income.

(ii) Estimated premium, deductible, coinsurance and copay to be paid with grant money for the estimated number of months of coverage under the MHIP not to exceed 1 year and the total funds requested not to exceed $10,000 a year.

(c) Certifies that the applicant will:

(1) Keep financial reports and records; establish a separate account to track expenditures under the grant for at least 3 years after the last expenditure.

(2) Maintain accurate records, including documentation of each transaction pertaining to the grant.

(3) Submit to the Department quarterly invoices for payment and an annual financial expenditure report containing the signature of the financial offer of the entity affiliated with the grant award.

(4) Send demographic and fiscal information on each individual covered to the CCSC at the end of the grant year period.

OR

- For each applicant that plans to pay for an applicant's treatment **not using the** Maryland Health Insurance Plan (Non-MHIP), the following must be submitted:

1. A completed enrollment application form for each individual for whom grant funds are being requested, including the individual's:

(a) Name;
(b) Phone number;
(c) Mailing address;
(d) County;
(e) Signature, or if the application is for a child younger than 18 years old, the signature of the child's parent or guardian; and

2. A letter written by the individual's physician on the physician's letterhead:

(a) Confirming:
(i) That the individual has been diagnosed with or treated for cancer; and
(ii) The dates of diagnosis or treatment; and

(b) Containing the physician's:
(i) Full name;
(ii) Address;
(iii) Specialty; and
(iv) Medical license number;

3. Proof of current Maryland residency for each individual for whom grant funds are being requested, in one of the following forms:

(a) Maryland driver's license or State identification card issued no fewer than 6 months before the application date;
(b) Lease or rental agreement;
(c) Property tax bill;
(d) Motor vehicle registration;

(e) Pay check or stub with name and home address;
(f) Utility bill;
(g) Voter registration card; or
(h) W-2 statement issued not more than 12 months ago;

4. Proof of annual family income for each individual for whom grant funds are being requested, including a copy of at least one of the following:
(a) Most recent income tax return;
(b) Most recent W-2 form;
(c) Two pay stubs for two:
(i) Consecutive pays; or
(ii) Pays in the same month;
(d) Social security entitlement letter; or
(e) Notarized letter stating that the individual is not working and does not have any income;

5. A signed application that:
(a) Includes a treatment plan for a total request not to exceed $20,000 per individual per year for each individual to be covered, including:
(i) The cancer treatment procedures;
(ii) CPT codes for each procedure; and
(iii) The Medicaid or HSCRC-regulated rate for each procedure;
(b) Documents the eligibility of the individual for the grant money, including:
(i) The number of individuals in the family of the individual for whom the applicant is applying; and
(ii) The family's annual household income;
(c) Certifies that the applicant:
(i) Shall reimburse the provider in an amount not greater than the Medicaid rate for the medical procedure or the HSCRC-regulated rate for the medical procedure performed, if the medical procedure is performed in an HSCRC-regulated facility; or
(ii) If the applicant is a medical provider, is willing to accept the Medicaid rate as payment in full for the cancer treatment procedures provided.
(d) Certifies that the applicant will keep financial records, as described in Regulation .16B of this chapter, and send relevant demographic and fiscal information on each individual covered to the CCSC at the end of the grant period;
(e) States that the funds under the grant will not be used to supplant any existing funding for this cancer treatment activity; and
(f) If the applicant currently receives funding for similar cancer treatment activities, lists the funding:
(i) Source;
(ii) Amount; and
(iii) Period for the activities.

Organization Application for Maryland Cancer Fund Cancer Treatment Grant

Please Print or Type Clearly

(Please complete for each individual in need of treatment.)

Name of Contact: _____
Name of Organization/Entity: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Name of Individual Patient Requiring Cancer Treatment: _____
Date of Birth: _____
Gender: _____
County of Residence: _____
Type & Stage of Cancer: _____

How did the individual patient learn of the Maryland Cancer Fund treatment grant?

_____

Please complete the following checklist for enclosures:

- ☐ Completed treatment application form (either Maryland Health Insurance Plan [MHIP] or Non-MHIP Treatment Application) for each individual for whom grant funds are being requested, including:
  - ☐ Proof of residency eligibility
  - ☐ Proof of annual family income or notarized statement of no income.
- ☐ Physician letter on physician's letterhead confirming individual diagnosed with cancer, treatment for cancer, or finding suggestive of cancer, date of diagnosis or treatment, specialty, medical license number (See template)
- ☐ Maryland Cancer Fund Cancer Treatment Plan and Budget
- ☐ Certification for Maryland Cancer Fund Cancer Treatment Grant
- ☐ Fiscal Budget Forms DHMH 432 A – H (as applicable)

Maryland Cancer Fund Cancer Treatment Application for
An Individual
For Funding of Direct Payment for Cancer Treatment of an
Individual Patient (not using Maryland Health Insurance Plan) ("Non-MHIP Treatment Application")

PLEASE COMPLETE ALL AREAS OF THE APPLICATION, Pages 1-3
(IF SOME AREAS DO NOT APPLY TO THE PATIENT, PLEASE MARK **Not Applicable**)

Instructions:

PAGE 1: **RESIDENCY ELIGIBILITY** – The patient receiving payment for treatment through the Maryland Cancer Fund (MCF) must be a Maryland resident.
Please provide a copy of ONE of the following documents displaying patient's name AND current home address:

- Maryland Driver's License
- Maryland State Identification Card (issued no fewer than 6 months before the application date)
- Lease or Rental Agreement
- Property Tax Bill
- Motor Vehicle Registration
- Paycheck or Stub with Full Name and Home Address
- Utility Bill (i.e. Gas and/or Electric Bill, Water Bill, Telephone Bill- residence phone only)
- Voter Registration Card
- W-2 Statement (not more than 12 months old)

PAGE 2: **INSURANCE ELIGIBILITY** – The patient is only eligible for the MCF Treatment Grant if the patient has no health insurance at the time of application for the grant and remains uninsured at the time of service delivery.

PAGE 2: **ANNUAL FAMILY INCOME** – Please list the total amount received from all sources before taxes are withheld. The patient must have an annual family income of not more than 250 percent of the federal poverty guidelines.

PAGE 2: **FINANCIAL ELIGIBILITY** – Proof of annual family income for the patient, including a copy of **at least one** of the following:

- **Two Pay-stubs** – Must be for two pays in a row or in the most recent month or two pays in the same month
- **Most recent income tax return**
- **Most recent W-2 form**
- **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount the patient will receive each month.
- **Notarized Statement** – If the patient is not working, this statement should state that the patient is **not** working and does **not** have **any** income, or that the patient has not had any income in the past 6 months. This is a legal document and must be stamped and signed by a notary public. (See sample patient's statement DHMH Form 4685).

PAGE 2: **FAMILY COMPOSITION** – To determine eligibility, please provide the number of individuals in the family of the patient needing treatment.

PAGE 3: **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. The patient's signature indicates: (1) the statements that the patient made are true; (2) the MCF has the patient's permission to verify the patient's information provided; and (3) the organization applying on behalf of the patient has the patient's permission to release information regarding the patient's medical, financial, and insurance information to in the MCF.

PATIENT INFORMATION (Please type or print)

Name: _____ _____ ____
Last First MI

Date of Birth: ☐☐/☐☐/☐☐☐☐
MM DD YYYY

Sex: ☐ Male ☐ Female

Marital: ☐ Separated ☐ Divorced ☐ Married ☐ Single/Never Married ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Check all that apply:

Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other (Specify) _____

Patient Currently Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____

Spouse Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____

Home Address: _____
Number, Street / P.O.Box

_____

_____ _____ _____ _____
City/Town State Zip Code County of Residence

Maryland Resident: ☐ Yes ☐ No

Home Phone: ☐☐☐/☐☐☐/☐☐☐☐

Work Phone: ☐☐☐/☐☐☐/☐☐☐☐ **Ext:** ☐☐☐☐

Cell Phone: ☐☐☐/☐☐☐/☐☐☐☐ **E-Mail:** _____

EMERGENCY CONTACT

Name: _____ _____ **Phone:** ☐☐☐/☐☐☐/☐☐☐☐
Last First

Address: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other (Specify): _____

Contact Person for Organization Applying:

Name: _____ _____ **Phone:** ☐☐☐/☐☐☐/☐☐☐☐
First Last

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Patient Name: _____
Date of Birth:_____

Maryland Cancer Fund Non-MHIP Treatment Application for an Individual Patient (Page 2 of 3)

INSURANCE ELIGIBILITY: Do you have any health insurance? ☐ Yes: _____ ☐ No

ANNUAL FAMILY INCOME: The total amount received per year from all sources before taxes are withheld.

	INCOME (Please indicate week, month or year)				FOR OFFICE USE ONLY **DOCUMENTATION**
Patient Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Spouse's Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Parents' Income (If patient is a dependent child on parents' income tax return)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Child Support	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Foster Child Supplement (If child(ren) counted in household composition)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Unemployment Insurance ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	**Start Date:** _____ **End Date:**	☐Yes ☐No ☐N/A Initial: _____
Workman's Compensation ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	**Start Date:** _____ **End Date:**	☐Yes ☐No ☐N/A Initial: _____
Social Security Disability Insurance ☐dependent child ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
Alimony ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: _____
TOTAL ANNUAL FAMILY INCOME			$.		

FINANCIAL ELIGIBILITY

In order to determine your financial eligibility for this program we need to collect information regarding household composition and family-income. PROOF OF INCOME MUST BE ATTACHED – (Your most recent Income Tax Return is preferred. However, W-2 Forms, Social Security Entitlement Letter, a minimum of 2 Pay Stubs in a row or in the most recent month, or a notarized letter stating "No Income and No Employment" can be substituted).

FAMILY COMPOSITION

Please list the names and ages of all family members. For a financially independent adult 18 years old or older diagnosed with cancer and one or more of the following: spouse; financially dependent child; or financially dependent relative. For a financially dependent child, the child and one or more of the following: parent, foster parent, or guardian; sibling living in the household; or half brother or half sister living in the household and indicate their relationship to the patient.

LAST NAME	FIRST NAME	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			
If there are more than five residing in your household, please attach a list of other dependents listed on your Income Tax Return with their name, age and relationship to patient.			

Total number of people in family (including patient): ☐

Patient Name: _____
Date of Birth: _____

State of Maryland
Maryland Cancer Fund Non-MHIP Treatment Application for an Individual Patient

PATIENT AGREEMENT

(Please read carefully before signing)

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under State law and would result in a denial of grant eligibility.

I authorize the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control, Maryland Cancer Fund (MCF) to verify any information provided by me on this form. I will provide proof of any information on this form as required by the MCF.

I agree to allow the _____
Name of Organization

to release the medical/financial/insurance information regarding my cancer treatment and the Maryland Department of Health and Mental Hygiene that administers the Maryland Cancer Fund.

_____
Signature of Patient or Parent/Guardian

_____
Name of Contact Person for Organization Applying
(Please Print or Type)

_____
Name of Patient
(Please Print or Type)

_____
Address of Contact Person
(Please Print or Type)

_____
Date of Application

_____
Office Phone of Contact Person

RETURN COMPLETED MCF APPLICATION TO:

Maryland Cancer Fund
Center for Cancer Surveillance and Control
Maryland Department of Health and Mental Hygiene
201West Preston Street, Room 400
Baltimore, Maryland 21201

For questions, please call (410) 767-3117

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Family Health Administration

Russell W. Moy, M.D., M.P.H., Director – Joan H. Salim, Deputy Director

Maryland Cancer Fund- Patient Statement Certifying No Income

I, _____, state that:

I am not employed at this time and receive no unemployment compensation, support, or income of any kind. I live with my _____ (parents, friend, relative, etc.) and receive only room and board.

I receive (check all that apply):

Yes ☐ No ☐ Food Stamps

Yes ☐ No ☐ Cash Assistance/Temporary Cash Assistance/TEMA

Yes ☐ No ☐ Housing Allowance (voucher)

_____ _____
(Patient Signature) (Date)

Notary Acknowledgement
STATE OF MARYLAND)
) SS
_____)

On _____, before me, the undersigned, a Notary Public in and for said County/City and State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged that she executed the same.

Subscribed and sworn to before me this _____ day of _____, 20____.

Witness my hand and official Seal.

_____
Notary Public in and for said
County/City and State

Notary Public: _____
Date: _____
My commission expires on _____

Physician Letter Certification of Diagnosis

Letterhead

Physician's Full Name
Address
Specialty
Medical License Number

Date

Dear Maryland Cancer Fund Coordinator:

This letter is to certify that _____ has been
Patient Name

□ diagnosed with **_____, on _____**or
Type of Cancer Date of Diagnosis

□ is being treated for _____, and began treatment on
Type of Cancer
_____, or
Date Treatment began

□ has finding suggestive of _____ and needs to obtain a cancer diagnosis.
Type of Cancer

Sincerely,

Physician's Signature

Maryland Cancer Fund Cancer Treatment Plan and Budget

Name of Organization/Entity applying for Grant: _____

Patient Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Comments: _____

_____

Treatment Plan for (date) _____ to (date) _____ Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	**Date Anticipated**	**CPT Codes Anticipated (if applicable)**	**Estimated Costs**	**Basis for costs (Medicaid or HSCRC-regulated rate for each procedure; OR MHIP rates)**
Sub Total for Treatment				
Indirect costs (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)				
Total Requested (Treatment + Indirect)				

Maryland Cancer Fund

Attachment B: SAMPLE Non-MHIP Treatment Plan and Budget Template for Paying Fee-for-Service

Name of Organization/Entity applying for Grant: _____Dorchester County Health Department: _____

Patient Name: _____Jane Doe_____ Date of Birth: _____01/01/1943_____

Diagnosis: _____Colorectal Cancer_____ Date of Diagnosis: _____02/07/2008_____

Comments: Client screened under CRF program. Found to have Stage II colorectal cancer. Needs surgery and chemotherapy.
_____

Treatment Plan for (date) _2/2008_____ to (date) ___10/2008 Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	**Date Anticipated**	**CPT Codes Anticipated (if applicable)**	**Estimated Costs**	**Basis for costs (Medicaid or HSCRC-regulated rate for each procedure)**
CT of Abdomen	*February,2008*	*74170*	*$226*	*Medical Assistance*
Hospitalization for colon resection with reanastamosis	*February, 2008*	*See below*		
Surgeon		*44140*	*$426*	*Medical Assistance*
Anesthesiologist		*44140-30*	*$142*	*Medical Assistance*
In-patient Pharmacy		*Various (list if known)*	*$500*	*HSCRC if regulated; Medical Assistance otherwise*
In-patient Laboratory, EKG, blood tests, etc.		*Various*	*$1,000*	*HSCRC if regulated; Medical Assistance otherwise*
In-patient Pathology		*88309*	*$236*	*HSCRC if regulated; Medical Assistance otherwise*

Procedure and frequency of Treatment	**Date Anticipated**	**CPT Codes Anticipated (if applicable)**	**Estimated Costs**	**Basis for costs (Medicaid or HSCRC-regulated rate for each procedure)**
Hospital room fee, 7 days		*UB92*	*7 x 1500 =$10,500*	*HSCRC*
Operating room fees		*44140*	*$3250*	*HSCRC*
Initial surgeon visit—in patient		*99222*	*1 x $ 24.50*	*Medical Assistance*
Surgeon visits x 7—in patient		*99232*	*7 x $ 16= $112*	*Medical Assistance*
Surgical out patient visits x 4	*February-April, 2008*	*99213*	*3 x 51.92=$155.76*	*Medical Assistance*
Oncologist out patient visits x 16	*March-September, 2008*	*99204 99212*	*1 x 136.30=$136.30 15 x 37.00 =$555*	*Medical Assistance*
Out-patient pharmacy	*March-September, 2008*	*Various (or list if known)*	*$5,000*	*Medical Assistance*
Out-patient laboratory			*$500*	*Medical Assistance*
Sub Total			***$22,763.56***	
Indirect (7% of $20,000 max.) (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)			***$1400***	
Total Requested			***$21,400***	

Maryland Cancer Fund

Attachment C: Sample Treatment Plan and Budget Template using Maryland Health Insurance Plan

Name of Organization/Entity applying for Grant: _____Somerset County Health Department_____

Patient Name: _____John Sample_____ Date of Birth: _____3/3/1930_____

Diagnosis: _____Prostate Cancer_____ Date of Diagnosis: _____1/2/2008_____

Comments: _____Diagnosed at hospital; no source of funds for treatment. Surgery recommended.

Treatment Plan for (date) __4/2008___ to (date) ____6/2008__ Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	**Date Anticipated**	**CPT Codes Anticipated (if applicable)**	**Estimated Costs**	**Basis for costs (MHIP rates)**
Maryland Health Insurance Plan (MHIP) $1000 PPO plan	*April 2008— September 2008*	*N/A*	*$370 x 6 months=$2220*	*MHIP+ $500, PPO Plan 3*
MHIP Buy Down for preexisting condition	*April 2008— September 2008*	*N/A*	*$37 x 6 months = $222*	*10% of premium*
MHIP deductible and co-payments	*April 2008— September 2008*	*N/A*	*$3000*	*MHIP maximum out of pocket expenses*
Sub Total for Treatment			***$5442***	
Indirect costs (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)			***$410***	
Total Requested (Treatment + Indirect)			***$5852***	

Certification for Maryland Cancer Fund Cancer Treatment Grant

The Maryland Cancer Fund (MCF) grant money I receive, as the applicant for my organization, will not be used to supplant any existing funding for cancer treatment of this individual patient.

Organization Name: _____
Individual Patient Name: _____

☐ I do not receive any other funding for payment and/or reimbursement for this individual's cancer treatment
(that is, either I do not receive any other funding for payment or reimbursement for *any* cancer treatment activities OR I receive funding for payment or reimbursement of cancer treatment but that funding is expended or obligated to other individuals for this Fiscal Year).

☐ I do receive other funding for payment and/or reimbursement for this individual's cancer treatment as listed below, but still request MCF funds:

Source	Title or Activity	Amount	Period for Activities

Rationale for need for MCF Funds:

- ☐ Estimated costs of cancer treatment exceed available funding for payment
- ☐ Other _____
  _____
  _____

I, as the applicant for my organization and on behalf of any others that receive MCF Treatment Funds, certify that:

- ☐ The individual meets the residency, insurance and income requirements of the Maryland Cancer Fund program.
- ☐ (Non-MHIP applicants) I shall reimburse the provider(s), (or if I am a provider I will accept) an amount not greater than the Medicaid or HSCRC- regulated rate (if applicable) for medical procedures performed.
- ☐ I will retain all records pertaining to this grant award for 3 years unless directed by the Maryland Department of Health & Mental Hygiene to retain longer.
- ☐ I will maintain as confidential all medical and financial information regarding the individual receiving treatment and his/her family.

I certify that I am (check all that apply):

- ☐ A Maryland Local Health Department
- ☐ A Department of Mental Health and Hygiene, Center for Cancer Surveillance and Control funded cancer screening program
  - ☐ Breast/Cervical Cancer Program
  - ☐ Cigarette Restitution Fund
  - ☐ Baltimore City Centers for Disease Control and Prevention Colorectal Screening Demonstration Program
  - ☐ Maryland Cancer Fund Cancer Early Detection/Secondary Prevention Grantee
  - ☐ Other: _____

_____	_____
Signature of Contact	Date
_____	_____
Name of Contact (Printed)	Name of Organization