Financial Assistance Application 2026

I. Applicant Information

Applicant's Name: _____ Date of Birth: _____

Email: _____ Date of Application: _____

Address: _____ Phone: _____

City, State, Zip: _____

Amount of Unreimbursed expense(s) requested with this application: $_____

Has Applicant applied for Gorges Givers Restricted Funds in the Past? Yes _____ No _____

If Yes, Date of Application/Amount Received, if any? Date _____ Amount _____

II. Qualification to Receive Funds/Acceptable Use of Funds

To determine qualification for Financial Assistance from the Schuyler Health Foundation Gorges Givers Restricted Fund, please complete Sections A and B below.

Section A – Applicant Qualifications (please, check all that apply)

Applicant:

_____ is a current cancer patient of one or more of the following licensed Medical providers for treatment (please, check all that apply);

- ☐ Schuyler Hospital and/or
- ☐ Cayuga Medical Center and/or
- ☐ Other Licensed Medical Facility where Applicant is receiving Cancer treatment, provided such Facility has been referred by a CHS provider to insure the most appropriate cancer care for the Applicant. Name of facility: _____;

_____ is an individual who identifies as female and who is 18 years or older;

_____ resides with Schuyler Hospital's service areas (includes Dundee, Ovid, Burdett, etc.)

Please note: The Maximum Annual amount available for any qualified recipient is $1,500.00 with a Lifetime Limit of $3,000.00.

Section B – Applicant's request for Specific Unreimbursable Expenses Qualifications

I affirm by my signature below that I understand the acceptable use(s) of any funds received from the Schuyler Health Foundation Gorges Givers Restricted Fund as noted below. And, that any funds distributed to me for unreimbursable expenses incurred in connection with my cancer care will be used solely for one or more of the qualifying purposes noted below.

_____ medical equipment and supplies;

_____ wigs and comfort clothing items;

_____ medication costs (prescription, non-prescription, nutrition supplements);

_____ medical provider services (physical therapy, reiki, etc.);

_____ rent, mortgage payments,

_____ motor vehicle payments;

_____ childcare/daycare/eldercare services;

_____ payments for utilities (heat, water, utilities, phone, internet, etc.); or

_____ other miscellaneous unreimbursed expenses related to cancer care

please specify: _____

I affirm by my signature below that I will use the financial assistance provided by the Gorges Givers Restricted Fund for unreimbursed expenses, as identified immediately above.

Signature: _____ **Date: _____**

Mail completed application to:
Attn: Amy Hurd, RN
Schuyler Hospital
220 Steuben Street
Montour Falls NY, 14865

Questions? Contact:
Amy Hurd, RN
Case Manager
(607) 535-8639 ext. 52284
ahurd@cayugahealth.org

For office use: *Approved (Initial: _____)* *Amount Granted $_____* *Date Check mailed _____*