HairToStay Subsidy Program

***HairToStay* Subsidy Program**
PO Box 219, Gloucester, MA 01931
Phone: 800-270-1897 Fax: 888-246-6527

The *HairToStay* Program

The *HairToStay* Subsidy program is designed to help people undergoing cancer chemotherapy who can't afford to pay for scalp cooling treatments. The program has specific eligibility guidelines and other requirements. The following will help you decide if you are eligible for participation.

Who Qualifies for a Subsidy?

In order to be eligible to receive a subsidy, you must:

- Demonstrate financial need — Your household income must be at or below 300% of the Federal Poverty Level and you must document that as described below in this application. To apply for a subsidy, your Total Household Income cannot be greater than the amount listed in the chart below.

Federal Poverty Levels

Household Size	Where You Live		
	48 Contiguous States and D.C.	Alaska	Hawaii
1	$36,180	$45,180	$41,580
2	$48,720	$60,870	$56,010
3	$61,260	$75,750	$70,440
4	$73,800	$92,250	$84,870
5	$86,340	$107,940	$99,300
6	$98,880	$123,630	$113,730
7	$111,420	$139,320	$128,160
8	$123,960	$155,010	$142,590

For each additional person in your household, add the following:	
48 contiguous states	$12,540
Alaska	$15,690
Hawaii	$14,430

- Be a chemotherapy patient who has been diagnosed with a solid tumor cancer. [Scalp cooling is not recommended for blood (hematological) cancer patients and those patients are not eligible for subsidy.]
- Be a full-time US resident receiving treatment in a medical facility located in the United States.
- Be already using or ready to use a scalp cooling system from one of the following Qualified Scalp Cooling Suppliers:
  - Dignitana Dignicap System
  - Chemo Cold Caps
  - Penguin Cold Caps
  - Arctic Cold Caps
  - Wishcaps

IMPORTANT: We do not subsidize scalp cooling treatment expenses incurred prior to your application being approved, only expenses incurred once your subsidy has been formally approved.

How You Will be Notified

You will usually be notified within one week of submission of a completed application regarding the status of your application. If you have not heard back, please contact us.

Amount of the Subsidy and How You Will be Reimbursed

Subsidy recipients will usually be reimbursed up to $250 per month up to $1,000 total. In order to be reimbursed, copies of statements from your scalp cooling treatment provider must be provided within one month of rental or charge. *HairToStay* will issue a check for the subsidy amount upon receiving each billing statement.

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Patient Instructions:

1. Complete all fields on page 2 and 3 of the application. Incomplete applications will delay the processing of your application.
2. Sign the application.
3. Send the application and your documentation to the *HairToStay* Subsidy Program by U.S. mail, fax or email to hairtostay@pap-apps.org.

YOUR INFORMATION

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Daytime Phone: _____

Social Security # or Green Card # _____ Date of Birth: _____

Email: _____
By providing your email you are giving us permission to contact you this way.

Fax: _____
By providing your fax you are giving us permission to contact you this way.

Gender: (Check One) ☐ M ☐ F

Will you be receiving chemotherapy treatment at University of California, San Francisco? ☐ Yes ☐ No

How did you first learn about *HairToStay*? (select one)

☐ Doctor or oncologist
☐ Nurse or medical administrative staff
☐ Infusion center
☐ Press or media coverage
☐ Friend or family member
☐ *HairToStay* website
☐ Internet search result
☐ Scalp cooling system supplier (please specify) _____
☐ The Rapunzel Project
☐ Other (please specify) _____

ELIGIBILITY INFORMATION

Residency Status: ___ U.S. Citizen ___Legal Resident ___Work Visa (attach a copy your work visa)

Total household income: _____

Required supporting documentation (select one):

☐ Applying before April 15 — copy of the first page of last year's tax return
☐ Applying after April 15 — copy of the first page of this year's tax return
☐ Not required to file a tax return — 4607-T form attached
☐ If on Social Security a copy of SSA 1099
☐ Copy of two most recent pay stubs for all employed household members
☐ Proof of all pensions, interest, alimony, child support and retirement payments for all household members

If applicant has no income then a letter is required from applicant's healthcare provider, advocate or other person or agency attesting to zero income.

My household size: _____

Check if true: ☐ I have no health insurance coverage (private or government) that pays for scalp cooling treatments.

Check if true: ☐ I am receiving no other subsidy or assistance to pay for my scalp cooling treatment. (This doesn't include support from family, friends, etc.)

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MEDICAL QUESTIONS

Please select the Scalp Cooling System you have chosen:

☐ Dignitana Dignicap System ☐ Chemo Cold Caps ☐ Penguin Cold Caps ☐ Arctic Cold Caps ☐ Wishcaps

Please select the Type of cancer you've been diagnosed. Also circle the Stage if you know.

Type	Stage (circle one)	Type	Stage (circle one)
☐ Breast Cancer	I II III IV	☐ Uterine	I II III IV
☐ Colorectal	I II III IV	☐ Ovarian	I II III IV
☐ Liver	I II III IV	☐ Urinary	I II III IV
☐ Pancreatic	I II III IV	☐ Brain	I II III IV
☐ Stomach	I II III IV	☐ Oral	I II III IV
☐ Skin	I II III IV	☐ Other: Please specify _____	I II III IV

On what date do you expect to receive your first (or next, if you've already started) scalp cooling treatment? _____

How many total scalp cooling treatments do you expect you will receive?_____

How many total scalp cooling treatments have you already received (if any)?_____

How will you be billed and how much do you expect to pay for your scalp cooling treatment?

- ☐ I will be billed separately for each treatment in the amount of _____
- ☐ I will be billed a monthly rental charge in the amount of _____
- ☐ I will be billed some other way — describe frequency and amount _____

On what date did you (or do you expect) to receive your first chemotherapy treatment? _____

Please provide your oncologist's contact information:

Name _____ Phone Number: _____

Please provide the contact information for the medical facility where you will be receiving your chemotherapy treatments:

Name _____ Phone Number: _____

Street Address _____ City _____ State_____ Zip _____

Optional Information: Please complete any of the following questions that you know the answer to.

What chemotherapy drug regimen(s) has your doctor prescribed? _____

How frequently do you expect you will receive chemotherapy treatment (e.g., twice a week, once every three weeks, once a month, etc.)? _____

How many total chemotherapy treatments do you expect to receive? _____

If you've been diagnosed with Breast Cancer, please select your Hormone Receptor/HER2 Status (select all that apply):

☐ ER-Positive	☐ ER-Negative
☐ PR-Positive	☐ PR-Negative
☐ HER2 Positive	☐ HER2 Negative
☐ Triple Positive	☐ Triple Negative

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THE AGREEMENT

You must sign this form before we can process your application.

This application will remain valid for six months from date of submission. After that time, you must submit a new application.

By signing this form, you signify that you understand and agree to the following:

HairToStay makes no guarantees regarding the appropriateness or effectiveness of any scalp cooling treatment and that I should consult with a medical professional before undergoing scalp cooling treatment.

All information I have provided in this application is accurate and complete to the best of my knowledge.

The *HairToStay* Subsidy Program reserves the right to request additional income verification or other qualification information before making a final decision on my application.

I have not been approved nor do I expect to be approved for insurance reimbursements or subsidy payments from any organization that will help pay the cost of my scalp cooling treatments. (Personal contributions from friends or family members are allowed).

I will notify the Program immediately if there is any change in my income status or if I obtain a subsidy from another organization.

I agree to participate in a short pre-treatment and post-treatment survey and I understand that *HairToStay* may publicly use information gained from those surveys (without any personal identifying information).

I give *HairToStay* permission to contact my oncologist and my infusion center to verify the information I have provided in this application, and to share this information with my scalp cooling provider.

I give you permission to contact me by phone and by email during and after my participation in the Program.

Applicant's Signature: _____ Date: _____

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