Oncology Caregiver Behavioral Health Fund Residency Verification

To complete grant processing, we will need to verify your residency and relationship to the Oncology Patient. Please complete, SIGN (required), and UPLOAD this form to the Patient Portal at healthwellfoundation.org/patientportal or fax it to 800-282-7692.

Section 1: Patient Information

Oncology Patient Name: ______________________

Address: ______________________

City: ______________ State: ______ Zip Code: ______

Phone: ______________ Email: ______________

Caregiver Name (Grant Recipient): ______________________

Phone: ______________ Email: ______________

Relationship to Oncology Patient: ☐ Spouse/Domestic Partner ☐ Other Family ______________ (Specify Relationship)
☐ Child/Parent

Section 2: Acceptable Documentation

The Caregiver and Patient must submit at least one document to confirm a shared residency/address. If both the Caregiver and Patient's name is listed together on one document that shows shared residency/address, additional supporting documentation is not required.

- 1040 (Preferred)
- Lease Agreement
- Social Security Annual Statement
- State Issued ID or Driver's License
- Homeowners or Renter's Insurance Policy
- Pension or Retirement Statement
- Mortgage Statement
- Bank Statement
- Voter Registration
- Residential Property Deed
- Residential Utility Bill
- Car Registration

By signing this Residency Verification, I hereby certify that:

- I am a legal resident of the same household as the Oncology Patient listed in Section 1.
- The Oncology Patient listed in Section 1 is a member of my immediate family AND
- I am the primary caregiver for the Oncology Patient.

By signing this Residency Verification, I hereby certify that I understand:

- The Oncology Caregiver Behavioral Health Fund offers assistance to eligible caregivers for treatments/products expressly covered by the program.
- While the program will make every effort to grant assistance when needed, the program is limited by available resources and may be discontinued or changed at any time; and
- Any identified patterns of inappropriate submissions to the program may result in my, or the entity I represent, termination from the program for a length of time as determined by the HealthWell Foundation.

Please Note: If proof of shared household residency and immediate familial relationship is found to be invalid, this may result in grant withdrawal.

X ______________________ ______________
Caregiver Signature (Electronic Signatures Not Valid) Date
(If undated HWF will deem the date-of-submission as the day of processing)

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Printed Caregiver Name