Submission Check List

These documents are required to be submitted for eligibility.

_____ Medical Information Form

**Must be completed and signed by health care professional*

_____ Patient Information Form

_____ Patient Release Form

**Must be signed by patient*

_____ Previous Calendar Year W-2

Optional Check List

These documents are not required to be submitted for eligibility but may help our grant review committee have a better idea of the applicants need. We encourage you to submit these documents, however they are not required.

_____ Letter from applicant explaining cancer diagnosis and what led to financial hardship

_____ Copied of eligible bills

_____ Most Recent Pay Stub

_____ Recent Bank Statement

_____ Photo of applicant

Submit application by mail or email to the following locations

Cancer Can't
PO Box 336
Four Lakes, WA 99014
OR
grant@cancercant.com

Dear Social Worker or Health Care Professional,

Cancer Can't requires that an applicant work with a social worker or health care professional to help them complete our application for emergency financial assistance. The health care professional or social worker will also serve as our main contact if questions arise regarding the patient's application.

Here is an overview of Cancer Can't procedures. Please contact us if you have any questions or concerns.

Cancer Can't Procedures:

1. The Medical Information Form and top portion of the Patient Information form needs to be completed by a social worker or health care professional. An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to verify the patient has cancer and is currently undergoing treatment by signing the Medical Information Form. Medical records do not need to be sent.

2. The Patient Information Form and Release Form need to be completed by the patient, including the patient's signature, include all supporting documentation

3. Please mail or email the completed paperwork to the address/email listed on the cover page. Once the application has been processed, Cancer Can't will contact the patient, social worker or health care professional via mail, phone or email to inform them of the grant details.

4. All pages of the application must be completed in order to be processed. Incomplete applications will be returned for completion and will not be reviewed until a completed application is submitted.

5. Upon receipt of the approval letter, the patient is required to complete the Bill Payment Form, submit copies of all bills to be paid, and/or indicate if gift cards are requested. Bills must be in the patient or spouse's name, or the patient must prove payment history. Please note all checks will be made payable to the vendor (e.g., Avista, City of Spokane, Qwest) and will be sent directly to the vendor. Cancer Can't will send patient notification of payment received.

6. Cancer Can't has a quarterly grant spending limit and will review applications on a first come first serve basis.

GENERAL GRANT GUIDELINES AND CRITERIA FOR FUNDING

General Grant Requirements

- Patient must be living in the Inland Northwest; Washington, Idaho or Montana
- Patient must be 18 years or older.
- Patient must have a cancer diagnosis verified by an Oncologist
- Patient must meet financial guidelines set by Cancer Can't.
- Patient is able to receive one general grant through Cancer Can't.

Application Requirements

- The Medical Information Form and top portion of the Patient Information Form must be completed by a social worker or health care professional.
- An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to sign the Medical Information Form to confirm the cancer diagnosis.
- The Release Form must be signed by the patient.

Eligible Requests

- Cancer Can't approves requests for basic living expenses such as rent or mortgage, food, gas and utilities.
- If approved for a grant, copies of all eligible bills to be paid must be submitted to Cancer Can't with address where payment is to be sent.
- If requesting assistance with rent, a copy of the first page of the lease or a letter from the landlord is required.
- Checks will be made payable to vendors and submitted to the vendor.
- Checks will not be made payable directly to patients.
- If approved, the grant expires after 90 days.
- A letter from the applicant explaining the cancer diagnosis, what led them to a financial hardship and their current financial needs.
- Supply the most recent pay stub, recent bank statement and a copy of the previous calendar years W-2 and tax filing.
- Please include a clear original photo (no photo copies) of the applicant.
- Applicant must sign the release, which gives the foundation your permission to publish on our website/newsletter a picture, a brief case history and grant summary, and agree to potentially take part in a promotional video to be used at future events which would allow us to raise more funds to help more patients.

MEDICAL INFORMATION FORMS (PAGE 4 & 5) TO BE FILLED OUT BY HEALTH CARE PROFESSIONAL

Patient Information:

First Name: ______________________________ Last Name: ____________________________

Date of Birth: ______________ Gender: M _____ F _____

Marital Status: ________________

Diagnosis: ____________________ Stage: ___________ Date of Diagnosis: _________________

Current Treatment (check all that apply)

_____ Chemotherapy Date of Last Treatment: ________________

_____ Radiation Date of Last Treatment: ________________

_____ Bone Marrow Transplant Date of Last Treatment: ________________

_____ Surgery Date of Last Surgery: ________________

_____ Palliative Care Date Entered: ________________

_____ Chemotherapy Date Entered: ________________

TO BE SIGNED BY TREATING ONCOLOGIST, REGISTERED ONCOLOGY NURSE, OR LICENSED MEDICAL SOCAIL WORKER

I attest the patient has/had cancer and is/was treated as stated above

X____

cancer CAN'T

Please inform us why the patient is in need of Emergency Financial Assistance (REQUIRED):
____
____
____
____
____
____
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____
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____
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____

<u>Clinic Information:</u>

Clinic: __________________________________ Oncologist: ______________________________

Address: ____ City: ________________________

State: ________ Zip: ________________ Phone: (______) ______-__________________

<u>Social Worker/Health Care Professional Information:</u>

Name: _____________________________ Phone: (______) _______-______________________

Clinic/Organization: ____

Address: ____

City: ______________________ State: _______ Zip: ________ Fax: (______) _____-__________

Email: ____

*Information regarding the qualifying amount for this patient will be emailed to you

cancer CAN'T

PATIENT INFORMATION FORM

Patient Information:

First Name: ___________________ Last Name:__________________________________
Address: ___________________________________ City: _________________________
State:______ Zip:_______ County:________________ Phone:___________________
Email:____
Is okay to leave a message on your phone? ___ Yes ___ No
Inform me regarding my application via ____Email or ____ Mail
Responsible Party (If different than above)
First Name: ___________________ Last Name:_________________________________
Address: __________________________________ City: _________________________
State:______ Zip:_______ County:________________ Phone:__________________
Email:____________________________ Relationship to patient:_________________
Please list the people in your household

Name	Date of Birth	Relationship
______________________________	____________	_________________________
______________________________	____________	_________________________
______________________________	____________	_________________________
______________________________	____________	_________________________
______________________________	____________	_________________________
______________________________	____________	_________________________

PATIENT RELEASE FORM

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Cancer Can't. I hereby give my permission that this application and all information provided can be sent to Cancer Can't and discussed with my health care professional. All information reviewed is confidential.

Patient Signature:____________________________________ Date:____________

Print Name:____

Please take some time to answer the questions below

I would like to be on Cancer Can't's mailing list? ___ Yes ___ No

How did you hear about Cancer Can't?

________ Social Worker Name: _______________________________________

________ Nurse Name: ____________________________________

________ Oncologist

________ Patient Financial Counselor

________ Patient Navigator

________ Friend Name:_____________________________________

________ Internet

________ Brochure

________ Other:____

Please provide additional comments regarding your situation that might be helpful when reviewing your application. If needed please attach a letter explaining further your financial hardship.

____

____

____

____

____

_________________________ (Attach additional page if needed)

All applications are kept confidential. Cancer Can't cannot meet every request, however some assistance is generally available. Families may be prioritized by need. Cancer Can't reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

Financial assistance is only available to residents of the Washington, Idaho & Montana.