



# Assisting Families Dealing with Cancer APPLICATION

## Home State Bank – Giving Hope Cancer Relief Fund Women and Children Combating Cancer Fund Watchdog Cancer Relief Fund

### Patient Information:

Name: \_\_\_\_\_ SS Number: \_\_\_\_\_  
Address \_\_\_\_\_ Date of birth \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Email \_\_\_\_\_  
Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_

### Applicant/ Contact Person- if different from patient

Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ Email \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone (Day) \_\_\_\_\_ Phone (Eve) \_\_\_\_\_

I have been diagnosed with Cancer (or am submitting this application on behalf of a minor who has been diagnosed with Cancer) and require assistance with costs associated with my treatment. I hereby give permission to the staff of the McPherson County Community Foundation to contact the parties listed in this application or attachments thereto for purposes of verification.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

Please attach the following information to this cover sheet:

- ◆ A brief medical history, including condition of the patient with regard to cancer.
- ◆ A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy.
- ◆ Signed verification letter from attending physician. The form is attached to this application.
- ◆ A listing of expenses, real or projected, for which the grant is being requested.
- ◆ A timetable for the expenditure of the grant.

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## Expense Listing

Type of Expense (refer to items listed below)	Name & Address of vendor	Amount requested

### *Items in consideration in making grants*

1. Shelter – To promote the cancer patient remaining in the comfort of his or her home
  - a. Rent/House payments
  - b. Utilities
  - c. Necessary repairs to HVAC, electrical, plumbing
  - d. Necessary handicap accessibility
  
2. Nutrition – To promote health and healing
  - a. Food and drink
  - b. Dietary supplements
  - c. Meal Preparation
  
3. Medicine
  - a. Medical and dental care that is not otherwise covered by insurance of government programs including but not limited to prescription and non-prescription medicine, hospital and hospice care, nursing care, attendant care.
  
4. Cleanliness – To promote health and healing
  - a. Personal hygiene products
  - b. Household cleaning, including products and cleaning person
  - c. Personal care attendant
  
5. Companion Animal Care – To promote psychological well being of cancer patient.
  - a. Where a treating physician recommends that a pet is beneficial to the patient, it will be termed "companion animal". Costs, including food, drink, and veterinarian care are eligible.
  
6. Transportation
  - a. Transportation costs to accomplish any of the above.
  
7. Recipient may receive \$500 per 12-month period. A new application must be completed to receive additional funds



Date \_\_\_\_\_

Physician's Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

Subject: Eligibility Verification

The McPherson County Community Foundation is currently administering three fund accounts to assist patients with cancer related illness. They are the Home State Bank – Giving Hope Fund, the Women and Children Combating Cancer Fund and the Watchdog Cancer Relief Fund. The purpose of these funds are to provide support to people who have experienced financial hardship resulting in a deterioration of the quality of life caused by cancer and related treatment. Items in consideration in making grants are shelter, nutrition, medicine, cleanliness, companion animal care, and transportation. A recipient may receive a total of \$500 for each 12 month period they are receiving treatments.

We understand you are a treating physician for \_\_\_\_\_. He/She has applied for benefits from the fund. In order to ensure funds are distributed to recipients meeting the criteria, would you please verify the patient has a cancer or cancer related illness by signing below and returning this letter in the enclosed envelope.

For questions regarding this fund, please contact our office at 620-245-9070 or via email at [becky@mcphersonfoundation.org](mailto:becky@mcphersonfoundation.org).

Sincerely,

Becky Goss  
Executive Director

\_\_\_\_ Yes, \_\_\_\_\_ does have a cancer or cancer related illness.

\_\_\_\_ No, \_\_\_\_\_ does not have a cancer or cancer related illness.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date