Assisting Families Dealing with Cancer APPLICATION

If someone referred you to MCCF, which fund did they suggest?

____Home State Bank – Giving Hope Cancer Relief Fund
____Women and Children Combating Cancer Fund
____None

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: _____

Phone (Day) _____ Phone (Eve) _____

Please attach a separate sheet to this cover page with the following information:

1. A brief medical history, including condition of the patient with regard to cancer.
2. A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy.
3. Signed verification letter from attending physician. The form is attached to this application and must be sent from the doctor's office directly to McPherson County Community Foundation.
4. A listing of expenses, real or projected, for which the grant is being requested.
5. A timetable for the expenditure of the grant.

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

Assisting Families Dealing with Cancer

APPLICATION

Items in consideration in making grants (Please keep this page for your use.)

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. Grant recipients should submit fuel receipts to the Foundation for transportation reimbursement costs to accomplish any of the above.

Recipient may receive $500 for expenses in items one through five above and $250 in fuel expenses 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 and the Women and Children Combating Cancer 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.

Sincerely,

Becky Goss

President / CEO

____ Yes, _____ does have a cancer or cancer related illness.

____ No, _____ does not have a cancer or cancer related illness.

_____ _____

Signature Date