Application - The Cancer Fund

GOLDEN BELT
COMMUNITY FOUNDATION

The Heartland Cancer Patient Care and Support Endowment Fund supports residents of Barton, Pawnee, Rush, or Stafford County, Kansas who are experiencing a temporary financial hardship caused by cancer. These funds provide aid to assist individuals who are financially needy with food, clothing, housing (including repairs), transportation, and medical assistance. Eligibility includes all the following:

- Be a Barton, Pawnee, Rush, or Stafford County, KS resident
- Be 18 years of age or older
- Must have a temporary financial need caused by a current cancer diagnosis
- Must lack the financial resources for food, clothing, housing, transportation, and medical assistance or have a household income that is at or below 400 percent of the U.S. federal poverty guidelines
- Be receiving active cancer treatment (some active methods include chemotherapy, radiotherapy, and/or surgery)
- Each applicant may apply for assistance once per calendar year

The application must be completed in full before submitting, including receipts for which you are seeking reimbursement. Submitting the application does not guarantee approval of an award. Your application will be reviewed for eligibility, additional information may be requested, and you will be notified of the status in writing. If approved, then you may be reimbursed for qualified expenses up to a maximum of $800 per calendar year, subject to funding availability.

PATIENT

First & Last Name: _____

Address: _____

City: _____ St:_____ Zip: _____

County: _____ Gender: _____ Date of birth: _____

Phone: _____ Email: _____

TREATMENT

Name of oncologist: _____

Type of cancer: _____Date of diagnosis: _____

What types of treatment are you receiving and how often: _____

_____

FINANCIAL

Number of people in your household: _____ Gross household monthly income: _____

Are there other hardship circumstances which are not reflected in your income that you would like to make us aware of (decrease in work hours, excessive medical bills) for eligibility purposes: _____

_____

EMPLOYMENT:

Are you employed? Full-time ___ Part-time ___ Unable to work due to treatment ___

Employer, if applicable: _____ Retired? Yes ___ No ___
Are you receiving disability? Yes ___ No ___ Social Security? Yes ___ No ___
Are you in the process of applying for other assistance? Yes ___ No ___ If yes, where _____

HEALTH INSURANCE

Do you have health insurance? Yes ___ No ___

If yes, indicate type of insurance (check all that apply):
Medicaid ___ Private Insurance ___ VA Program ___
Medicare only ___ Medicare + Medicaid ___ Medicare plus other supplemental coverage ___
Dental insurance ___ Cancer Insurance ___

Are prescription drugs covered? Yes ___ No ___

OTHER:

Are you receiving assistance from any other organization/person/fundraiser? Yes ___ No ___

Please list: _____

NEEDS:

Please chart how this grant will be used and **attach paid receipts you wish to be considered for reimbursement**. Receipts must be dated within the last 6 months. Chart below must be completed.

	Vendor (*ABC Company*)	Amount
Food *(additional groceries, food during travel, nutritional supplements, meal delivery services)*		$
Clothing *(special types of clothing necessary after medical procedures)*		
Housing *(rent or mortgage payments, home repairs, household modifications for accessibility purposes, temporary lodging for medical purposes)*		$
Transportation *(vehicle payments, public transportation, repairs, fuel, maintenance, travel expenses)*		$
Medical Assistance *(caregiving, prescriptions, over-the-counter medicines, medically necessary clothing, medical supplies, equipment, prosthetics, bills not covered by insurance)*		$
Other *(Other types of aid dependent upon patient's needs)*		$

Contact Person - if different than applicant

Print Full Name: _____ Phone: _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Records to be used or disclosed pursuant to this authorization may contain information subject to special protections pursuant to 42 C.F.R. 164.508, 42 C.F.R. Part 2, K.S.A. 65-5601 et seq., and K.S.A. § 65-6001 et seq. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

By applying, **you authorize the confirmation of a cancer diagnosis as verified by your treating physician and pathology report** to Golden Belt Community Foundation (GBCF).

GBCF does not condition payment or eligibility for benefits on whether the application and authorization are signed.

All grants by GBCF are awarded in an objective, nondiscriminatory basis. Qualified expenses for reimbursement must be reasonable and necessary and cannot be payments for expenses otherwise covered by insurance or other reimbursements, or income replacement payments, such as payments of lost wages, lost business income, or unemployment compensation.

Grants to individuals for charitable purposes are generally not taxable but we recommend you contact your tax professional for final determination.

This authorization is valid until written revocation has been received by GBCF, and you may revoke this authorization at any time. Additional information may be requested to make a better-informed decision regarding the status of your application. All decisions are final, and you will be notified of the status in writing. Individuals may only receive assistance from one GBCF Hardship Fund, per calendar year. Funding is subject to availability.

Applicant Signature: _____ Date:_____

Please allow up to 30-45 days to process application requests.
Applications are reviewed on or about the 1st day of each month.
Assistance is subject to funding availability.