*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](mailto:info@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 some 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 3 & 4) 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic Information:**

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oncologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social Worker/Health Care Professional Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic/Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_ Fax: (\_\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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.