Dear Social Worker or Health Care Professional,

Cancer Can't requires an applicant to 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 the Cancer Can't grant 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 needs to be completed by the patient, including the patient's signature and all supporting documentation.
3. Please mail or email the completed paperwork to the address/email listed on the Checklist page. Once the application has been processed, Cancer Can't will contact the patient, social worker or health care professional via phone or email to inform them of the grant details.
4. All pages of the application must be completed to be processed. Incomplete applications will be returned for completion and will not be reviewed until a completed application is submitted.
5. Bills must be in the patient's or spouse's name, or the patient must prove payment history. Please note all checks will be made payable to the vendor (ex: Avista, City of Spokane, Progressive) and will be sent directly to the vendor.
6. Cancer Can't has a quarterly grant spending limit and will review applications on a first-come, first-serve basis in order of need.
7. Applicants must sign the release, which gives the foundation permission to publish on our website/newsletter a brief case history, grant summary and agree to potentially take part in a promotional video to be used at future events allowing us to raise more funds to help more patients.

General Grant Guidelines and Criteria for Funding:

General Grant Requirements:

- Patients must be living in the Inland Northwest (Counties within WA, OR, ID or MT)
- Patient must be 18 years or older
- Patients must have a cancer diagnosis verified by an Oncologist and currently in treatment
- Each patient is eligible to receive one grant from Cancer Can't during their lifetime

Application Requirements:

- Application completed and signed by appropriate parties as stated above
- Full copy of the patient's most recent bank statement
- If requesting assistance with rent, a copy of the first page of the lease or a letter from the landlord is required
- Copies of all eligible bills to be paid must be submitted with the application to Cancer Can't as well as the address where payment is to be sent if approved

Additional Supporting Documents (Not Required):

- A letter from the applicant explaining their cancer diagnosis, what led them to financial hardship and their current financial needs
- Previous calendar year W-2
- Most recent paystub

Approved Grant Requests:

- The Grant Committee reviews each application based on a first-come, first-serve basis and is approved based on a majority vote
- Cancer Can't approves requests for basic living expenses such as rent or mortgage, auto loans, home/auto insurance and utilities
- Checks will be made payable to vendors and submitted to the vendor for the patient
- Checks will NOT be made payable directly to patients
- If approved, the grant expires after 90 days
- Grant payments are a one-time payment per patient, per lifetime

Grant Application 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

_____ Full copy of patient's most recent bank statements *Must include all pages of statement

_____ Copies of eligible bills the patient would like considered

These documents are **optional** but may provide the grant committee with a more comprehensive understanding of the patient's needs.

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

_____ Previous calendar year W-2

_____ Most recent paystub

Submit grant application by mail or email to the following:

info@cancercant.com

OR

Cancer Can't

PO Box 336

Four Lakes, WA 99014

cancer CAN'T

MEDICAL INFORMATION FORM

* 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):

_____

_____

_____

_____

_____

_____

_____

_____

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_____

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_____

_____

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**

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 _____ Phone

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 to ensure 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 Cant'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 Washington, Oregon, Idaho & Montana.