

Qualifications:

1) Need to be a resident of Adams County 2) Has been diagnosed and is being treated for cancer 3) Failure to completely fill out form may result in denial of request

Client Information

Full Name:				
Date of Birth:		Age:		
Mailing Address:				
Residential address (if different from abov	/e)		
Phone: (260)		_ / Cell		
Email Address:				
Type of Cancer:		Diagnosed [Date:	
			nds from Adams County unt Received:	v Cancer Coalition in the
If client is a Dep	<u>endent:</u>			
Name(s) of Parent or	Legal Guardian:			
Address:				
Phone: (Dav)	(Night)	(Cell)	

Name(s) of Parent or Legal Guardian:						
Address:						
Phone: (Day)	(Night)	(Cell)				
Email:						
Relationship to Child:						
Child lives 50+% / time with	both parents /	_ Mother / Father				

Please explain the client's circumstances, to include: (You may attach another paper to this form.)

- Description of illness;
- Date of onset of diagnosis;
- Most recent prognosis
- Frequency, duration and description of treatment
- Treating physician(s)

Is there anything else that you would like the Adams County Cancer Coalition to know about you and your family?

Family Information

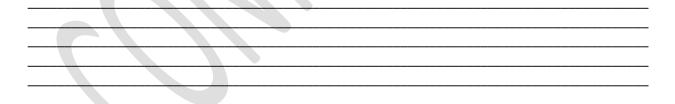
Who else resides in your household (Please include: name, age, relationship)

1)
2)
3)
4)
Employment:
Female, Head of household:
Number of hours employed outside of home per week
Place of Employment and phone number:
Title of Position:
Male, Head of Household:
Number of hours employed outside of home per week
Place of Employment and phone number:
Title of Position:

Do you have medical insurance? No/Yes If Yes, please list all that apply
MedicareMedicaidOther
How long have you lived in Adams County?
How did you hear about Adams County Cancer Coalition?
What kind of funds are you requesting?
Medical Expenses; Amount Requested
Medication; Amount Requested
Bills (water, electric, gas, etc.) Amount Requested
Mortgage Assistance; Amount Requested
Lodging/Food for Caregiver; Amount Requested
Hospice Services; Amount Requested
Other; Amount Requested

***Requests: A person may ask for up to \$1000 per request. At this time, we have a \$2000 cap per individual per year and a lifetime cap of \$5000 per person.

Please explain in detail what the funds will be used for.



Please Note:

The Adams County Cancer Coalition (ACCC) will distribute funds by gift cards or direct payment to a business. Additional information may be required. This application does not guarantee that you will receive the funding that is requested. This application will be submitted to the ACCC Executive Board for review and you will be contacted by a board member. All requests for funds need to be received by the first Monday of the month. All claims will start the review process by the first Tuesday of the month and clients will be notified approximately 2 weeks after claims are reviewed.

I certify that the information provided on this application is complete and accurate to the best of my knowledge. Falsification of information may result in termination request. I give the Adams County Cancer Coalition permission to contact my physician to verify information on this application is true.

Physicians Information:

Physician's Name:	_Phone:
Patient's Signature:	Date:

Forms can be mailed to: ACCC, P.O. Box 215, Decatur IN 46733 or emailed to adamscountycancercoalition@gmail.com