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 above) _____

Phone: (260) _____ / Cell _____

Email Address: _____

Type of Cancer: _____ Diagnosed Date: _____

Has the client or immediate family members received funds from Adams County Cancer Coalition in the past? _____ When: _____ Amount Received: _____

If client is a Dependent:

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

____ Medicare ____Medicaid ____Other _____

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**