

Southeastern Cancer Care Grant Program

We are a nonprofit organization assisting cancer patients in Eastern North Carolina with basic living essentials while they undergo treatment.

Program Qualifications

- Be **actively** undergoing treatment for cancer including radiation, chemotherapy, or within 3 months of an oncology related surgery.
- Live or recieve treatment in Wayne, Sampson, or Onslow Counties.
- Meet the income requirements. Our program uses the Federal Poverty Guidelines. Assets are not used to determine the level of assistance received.

Application Parts

- 1. Completed Application
- 2. Recent tax return.
- 3. Signed Treatment Verification Form from Oncology Provider.

We can help with:

Gas, groceries, car insurance, oncology prescribed medication, rent/mortgage, power/electric bills, water/sewer bills, and natural gas/propane bills.

Please submit all application parts by email: dsutton@cancersmoc.com, fax: 919-429-4316, or mail: 203 Cox Blvd Goldsboro, NC 27534.

Please allow 72 hours for your application to be processed. We are not an emergency fund and cannot provide immediate assistance. Please remember you must actively be on treatment to qualify for the program. If you are currently on treatment, please submit your application as soon as possible to ensure you meet all qualifications. If you have been charged with a felony or misdemeanor other than a minor traffic violation within the past 10 years, you will not be eligible for assistance. If you fail a drug test while enrolled in the program, your assistance is immediately terminated, and you will not be eligible to reapply.

Questions? Call 919-587-9056 or visit www.southeasterncancercare.org.

Southeastern Cancer Care Grant Application



Name (First, Middle, Last)	
Street Address	
City	Zip Code
Email	Date of Birth
Phone Number	Marital Status
Number of Dependents 18 years of age or under	Cancer Diagnosis
Treatment Plan	
Oncology Doctor	Oncology Practice

Gross Monthly Income

di oss Montiny income			
	Your Monthly Income	Spouse Monthly Income	
Salary			
Social Security			
SSI			
Disability			
Pension or VA			
Unemployment			

Total Yearly Income ______

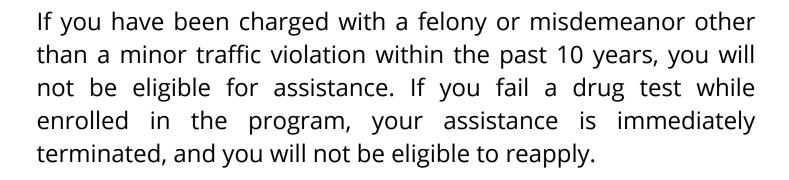


Southeastern Cancer Care Grant Agreement

	I understand I must meet all eligibility guidelines including being on active treatment as	
Initial	—defined by chemotherapy, radiation, or within 3 months of an oncology-related surgery.	
 Initial	I understand this grant is for the term of six months and is for the amount of \$1,000. \$500, or \$250 depending on my income level.	
 Initial	I understand that this grant will last up to six months ${f or}$ until the funds are exhausted, whichever comes first.	
	I understand that if I exhaust my grant funds before the six month term is up, I will not be eligible for any additional funding until I am eligible to reapply for the grant.	
Initial 	 I understand that I will have to reapply for this grant every 6 months. 	
Initial		
	I understand that if I am requesting assistance with bills I must submit them to staff at least 10 business days before the due date. I also understand that all bills must be to a legitimate business, mortgage holder, or housing authority. SCC will not pay	
Initial	money owed to friends, family members, etc. If SCC staff is unable to verify the business listed on the bill, then the bill will NOT be paid.	
 Initial	I understand that if I choose assistance with gas and groceries, I am only allowed tw gift cards each week. If I exhaust my grant, I cannot get more cards until it is time to	
miliai	reapply. I understand that if I am receiving treatment somewhere other than Southeastern	
	Medical Oncology Center and live outside of a 20-mile radius of a Southeastern Medical Oncology Center location, I can request a gas and grocery card be mailed to me every week. I assume all risks of the cards being mailed, and understand any cards lost in the mail will not be replaced and will still count against my grant amount. I	
Initial	understand it is my responsibility to request the cards be mailed to me every week. I understand that if I am receiving treatment at Southeastern Medical Oncology Center, I am not eligible for cards to be mailed to me.	



Southeastern Cancer Care Drug Policy



I acknowledge that I have read and understand this policy.



Name	Relationship	Phone Number
Name	Relationship	Phone Number
•	elow about what assistance yo act your grant approval in any	•
·	assistance with: (check all th	•
Help with gas	☐ Medication	app-y/
Help with groceries	☐ Rent /mortga	ge assistance
Paying bills		
	:	
Do you currently have overc	due bills? U Yes U No	
Are you in danger of being	evicted?	
Are you in danger of power/	water/heat being turned off?	☐ Yes ☐ No
Do you have reliable transp	ortation to and from your medi	ical appointments? 🗌 Yes 🔝
accurate. I understand that documentation upon request through Southeastern Canochange of condition or circle fraudulent information provide grounds for denial of as	et I may be required to provest for the purpose of determiner Care. I agree to inform Soumstances that might impact yided or my refusal to cooperates sistance or termination from	rovided herein is complete and ride additional information and ning my eligibility for assistance outheastern Cancer Care of and my eligibility. Any untruthful complete with the eligibility process mathe program. I also understand intry patient assistance program.
Signature		Date

Southeastern Cancer Care Grant Application



Treatment Verification Form To Be Completed by a Treating Physician

** This information is necessary to complete the patient's application **

Patient Name:	Patient DOB:			
Physician Name	—— NPI Number			
Facility/Practice Name				
City	Fax			
Office Contact Name and Number				
Patient's primary cancer diagnosis				
Date of diagnosis				
Treatment plan (please include names of chemotherapy medication)				
Treatment start date				
Treatment Is (circle all that apply):				
Started Paused Discontinued Sche	duled			
I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of Southeastern Cancer Care's Grant Program, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Program. I understand that application to the Southeastern Cancer Care Grant Program does not guarantee financial assistance.				
Physician Signature	Date			

Please fax the completed form to 919-429-4316 or email it to dsutton@cancersmoc.com

If you have any additional questions, please call us at at 919-587-9056.