SOUTHEASTERN CANCER CARE
Cures for the Colors

Southeastern Cancer Care Grant Program

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

Program Qualifications

- Be **actively** undergoing treatment for cancer - including radiation, chemotherapy, or within 3 months of an oncology related surgery.
- Live in North Carolina east of Interstate 95 or in a county that has I-95 within its boundaries.
- 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. Proof of income. Submit **either** W-2, 3 months of consecutive pay stubs, copy of recent bank statement, copy of social security earnings, or tax return.
3. Signed Treatment Verification Form from Oncology Provider.

How we can help

We can help with gas cards, grocery cards, utility bills, and oncology-prescribed medications.

Please submit all application parts to Emma Barnes via email at cfc@cancersmoc.com, fax them to 919-429-4316, or mail them to Emma Barnes 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 _____ Marial Status _____

Number of Dependents _____ Cancer Diagnosis _____

Treatment Plan _____

Oncology Doctor _____ Oncology Practice _____

Gross Monthly Income

	Your Monthly Income	Spouse Monthly Income
Salary		
Social Security		
SSI		
Disability		
Pension or VA		
Unemployment		

Total Yearly Income _____

Southeastern Cancer Care
Grant Agreement

_____ Initial — I understand I must meet all eligibility guidelines including being on active treatment as 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 **or** until the funds are exhausted, whichever comes first.

_____ Initial — 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 my utility bills I must submit them to staff at least 10 business days before the due date.

_____ Initial — I understand that if I choose assistance with gas and groceries, I am only allowed one gift card each week unless I choose the two cards every two weeks option.

_____ Initial — 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 two weeks. **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 understand it is my responsibility to request the cards be mailed to me every two weeks. **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

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.

I acknowledge that I have read and understand this policy.

_____

Signature Date

Authorized Individuals

Please list individuals below who have permission to speak to us on your behalf.

Name	Relationship	Phone Number
Name	Relationship	Phone Number

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility for assistance through Southeastern Cancer Care. I agree to inform Southeastern Cancer Care of any change of condition or circumstances that might impact my eligibility. Any untruthful or fraudulent information provided or my refusal to cooperate with the eligibility process may be grounds for denial of assistance or termination from the program. I also understand the above information may be provided to other third party patient assistance programs on my behalf.

Signature _____ Date_____

For Internal Use Only

Submission Date_____ Type of Cancer_____

Approval Status_____ Treatment _____

Grant Amount_____ Referring Provider _____

Effective Date _____ Notes_____

Expiration Date_____

Signature of Southeastern Cancer Care Representative_____

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 _____ Telephone_____

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 length _____

Treatment Is (circle all that apply):

Started Paused Discontinued Scheduled

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 cfc@cancersmoc.com

If you have any additional questions, please contact Southeastern Cancer Care at 919-587-9056.