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 months of an oncology related surgery.
- Live 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.
3. Signed and dated letter from your Oncologist detailing your current diagnosis and treatment plan.

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 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.

Personal Information

Name (First, Middle, Last) _____

Street Address _____

City _____ Zip _____

E-mail Address _____

Diagnosis (What type of cancer do you have?) _____

Date of Birth _____

Treatment Plan (chemo, radiation, surgery, etc) _____

Marital Status SINGLE MARRIED WIDOWED # Of Dependents _____

Home Phone _____ Mobile Phone _____

Gross Monthly Income

Income	Monthly	Spouse	Yearly
Salary	_____	_____	_____
Pension	_____	_____	_____
Social Security	_____	_____	_____
SSI Supp Income	_____	_____	_____
Disability	_____	_____	_____
Unemployment	_____	_____	_____
Alimony/Child Support	_____	_____	_____

Authorized Individuals

(Please list below who you would like to authorize on your behalf to work with the organization.)

_____ _____ _____

(*First and Last Name*) (*Relationship*) *(Phone Number)*

_____ _____ _____

(*First and Last 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.

Applicant Signature: _____ Date: _____ / _____ / _____

Internal Use Only

Submission Date: _____ / _____ / _____

Approved for: $_____

Effective Date: _____ / _____ / _____

Expiration Date: _____ / _____ / _____

Type of Cancer:_____

Treatment:_____

Signature: _____

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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 the Community Development Coordinator at least 10 business days before the due date.

_____ Initial — I understand that I am only allowed one form of assistance each week unless I choose the every two-week option for gas and grocery cards

_____ 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**.

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Southeastern Cancer Care 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