Cancer Charity Fund Application

This fund is designed to assist cancer patients with non-medical expenses, including but not limited to rent, mortgages, childcare, and other living expenses. We will review all applications when received, and funds will be distributed quarterly unless otherwise noted in the financial request. As funds are available, we will make grants to eligible applicants in the amounts that we, in our sole discretion, determine. We may ask for further information depending on the size of the request and information given by the patient.

Eligibility Requirements:

- Applicants must be cancer patients or caregivers of a cancer patient.
- Applicants must reside in Deschutes, Jefferson, or Crook County, Oregon.
- Expenses must be directly related to the support of the applicant or their family while undergoing cancer treatment.
- No questions will be asked that violate HIPAA (Health Insurance Portability and Accountability Act) regulations.

Section 1: Consent and Declaration

- **Certification by Applicant**
- I understand that applying for a grant from FHC Crush Cancer Inc. is voluntary but that I will not be considered for any funds if I do not submit a complete application along with the supporting documents necessary to substantiate my request for funds.
- I also understand that I must use any funds received from FHC Crush Cancer Inc. only to pay for non-medical expenses associated with my cancer treatment or caregiving responsibilities.

- **Signature**: By signing below, I apply for a grant of the funds requested and I certify that the information I have provided in this application is true and accurate.
- Signature: _____
  Date: _____

Section 2: Applicant Information

1. **Full Name**:
2. **Address** (Must be within Deschutes, Jefferson, or Crook County, Oregon):
3. **Phone Number**:
4. **Email Address**:
5. **Preferred Method of Contact** (Email / Phone / Text):

Section 3: Financial Assistance Request -

10. **Type of Financial Assistance Request**:
    (Please check all that apply)
    - Rent or Mortgage Assistance
    - Childcare Expenses
    - Utility Bills
    - Other (Please Specify)

    Date funds needed by: (if applicable) _____

11. **Amount of Financial Assistance Requested**:
    (Please provide the estimated amount needed for each category selected above.)

12. **Description of Financial Need**:
    (Briefly explain how the requested funds will help cover your living expenses during treatment.)

13. **Supporting Documentation**:
    (Please attach any relevant documentation that shows the financial need, such as bills, rent agreements, or other proof of the expenses for which you're requesting funds.)

To pay a request, the foundation will need to pay the vendor directly. Reimbursement is not possible for past expenses. Please provide a bill, contact or specific information with your application.

The basic areas the foundation will fund are lodging, fuel, food, utilities and housing.

It is up to the foundation to decide on a case by case basis for requests outside the above list.

Section 4: Personal and Family Information

14. **Are you the primary caregiver for others?** (Yes / No)
    If yes, please briefly describe the individuals who rely on you for care (children, elderly parents, etc.).

15. **Do you have health insurance coverage?** (Yes / No)
    If yes, does your insurance cover the requested expenses? (Please describe briefly.)

16. **Have you received financial assistance from any other organizations or sources?** (Yes / No)
    If yes, please provide details.

Section 5: Tri County Residency Verification

17. **How long have you lived in Deschutes, Jefferson, or Crook County?**:
    (In years/months)

18. **Current Residential Address**:
    (Street, City, State, Zip Code)

Submit Application:

Please submit the completed application along with any required supporting documents via:

- Email: crushcancer@fhcvineyards.com
- Mail: 70450 NW Lower Valley Dr Terrebonne, OR 97760

Cancer Diagnosis and Verification Information

1. **Please share your story:**
   (Please specify the type of cancer diagnosed. If unsure, please describe in your own words.)

2. **Date of Diagnosis**:
   (MM/DD/YYYY)

3. **Currently Receiving Treatment?** (Yes / No)

4. **Treatment Facility**:
   (Please provide the name of the clinic or hospital where you are receiving treatment. No medical records will be requested or shared.)

Please have the above information signed off below by a treating physician, nurse practitioner, nurse or social worker

Treatment Verification

Name _____

Organization/Facility_____

Signature _____

Patient Consent:

Patient Name:_____

Patient Signature _____