# 2018 Guidelines

In order to be considered for funding through the Women's Cancer Fund, please understand and follow these instructions:

1. The Women's Cancer Fund is a **quarterly distribution program**. **ALL** applications must be submitted by a social worker/patient navigator/cancer care specialist/doctor or treatment office staff member* (* must be an RN, NP, PA-C, DO or MD).
   ***Any application submitted by a patient or other party other than who is listed ***will not be considered***.***
2. Open submission periods for quarterly applications are as follows. Applications received before or after the open period will **NOT** be considered.
   a. **Q1:** *March 1st – 7th*
   b. **Q2:** *June 1st – 7th*
   c. **Q3:** *September 1st – 7th*
   d. **Q4:** *December 1st – 7th*
3. The program does NOT approve applications on a first-come, first served basis. All requests will be reviewed individually and considered for funding after each quarterly deadline.
4. Only requests submitted on this form or online via social worker/medical personnel (through the secure web link provided to them) will be considered for funding.
5. All patients must be currently receiving active cancer treatment to qualify for consideration.
6. A maximum of $250 may be approved per family, per year.
7. All sections of the application must be completed. Failure to complete the entire application will result in ineligibility of funding.
8. Only utility and rental fee bills will be considered. A utility request is defined as a heating, electrical or water bill. Cell phones, cable payments, mortgage payments, car payments, insurance or tax bills, medical payments and transportation costs are not eligible for funding.
9. Copies of all bills or the rental agreement (if rental assistance is being requested) must be submitted with application. IF there is NO FORMAL rental agreement, a letter from the landlord/rental management company may be accepted ONLY when NOTARIZED. A hand-written letter, typed letter or an email letter will not be considered without notarization.
10. A brief narrative describing the patient's situation and the family's need must be included and written by the social worker or hospital personnel. Be sure to include any additional, compelling and relevant information as this narrative plays a vital role in the application selection process.
11. Applications received after the quarterly deadline will not be considered for funding in that current funding period. Applicants may, however, reapply the following quarter by submitting new and/or updated utility bills.
12. If the application is approved, check(s) will be made payable to each utility company and mailed directly to the family.

13. Social workers or hospital personnel will receive notification (approved or declined applications) via email. Patients will NOT be contacted by Women's Cancer Fund/CRFI staff regarding application status.
14. If the check is not cashed within 60 days of printing date, Cancer Recovery Foundation International has the right to cancel the check.
15. Applications may be faxed or emailed to the following location:
    a. Fax: 717.545.7602
    b. Email: info@cancerrecovery.org


# 2018 Application

**(Please Print Legibly)**



Date: _____

## Section 1: Family Information

Patient's Name: _____

Birth Date: _____ Gender: _____ Male _____ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (_____) _____

Email Address: _____

Patient's place of employment: _____

Sources of monthly income (include dollar amounts):

Employment: _____ Unemployment: _____ Child Support: _____

Disability: _____ Welfare: _____ Food Stamps: _____

Other: _____

Total yearly family income (including costs listed above): _____

## Section 2: Health Information

Diagnosis: _____ Date of Diagnosis: _____

Name of Physician/Oncologist: _____

Hospital/Treatment Facility: _____

Social Worker/Hospital Personnel: _____ Title: _____

Telephone: (  ) _____ Fax: (  ) _____

Email Address: _____



## Section 3: Request for Funding

Please check the appropriate box(s) for the type of funding being requested. Additionally, ***list each company, the cost associated with the bill, its due date and the address for payment.***

☐ Rent ☐ Utility*

**Company:** _____ Cost: _____ Due: _____

Address: _____

**Company:** _____ Cost: _____ Due: _____

Address: _____

* A utility request is defined as a heating, electrical or water bill. Cell phones, Cable payments, mortgage payments, car payments, insurance or tax bills, medical payments and transportation costs are not eligible for funding.

## Section 4: Copies of Utility Bills or Rental Agreements

Attach copies of all utility bills and/or rental agreement being considered for funding.

## Section 5: Narrative from Social Worker/Hospital Personnel (MUST BE INCLUDED)

**Attach a brief narrative describing the patient's situation and the family's need. This information should be written by the social worker or hospital personnel. Be sure to include any additional, compelling and relevant information.**

## Section 6: Review and Sign

I have reviewed this application and, to the best of my knowledge, this information is true and accurate.

Patient's Name (Print): _____

Signature: _____ Date: _____

Social Worker/Hospital Personnel (Print): _____

Signature: _____ Date: _____

Applications may be faxed or emailed to the following locations:

Fax: 717.545.7602
Email: info@cancerrecovery.org