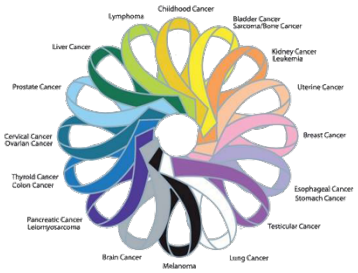

Cancer Fund Application Checklist

The following documents are needed to complete your application for the Cancer Fund:

- ☐ Application, including budget form
- ☐ Copy of Driver's License or ID
- ☐ Copy of diagnosis or treatment plan from medical provider. This can also be a simple letter from your medical provider indicating you are receiving care for cancer.

Documents can be delivered to MFC via:

- Mail: Mountain Family Center, PO Box 638, Granby CO 80446

- Email: katie@mountainfamilycenter.org

- Fax: 970-557-3124

- In Person: 480 E. Agate Ave, Granby CO 80446
(business hours are Mon-Thurs 9am-3pm, Fri 9am-noon)

You will be notified within 10 business days about your application approval. Once approved, you can start submitting expenses for reimbursement. Expenses can go back 12 months from date of application and each recipient is eligible for up to $5,000 in reimbursement per year (subject to change). To receive reimbursement, we will need copies of receipts for all expenses EXCEPT mileage. Mileage is calculated using the starting and ending address of each trip at $0.60/mile. It can be helpful to keep a trip log with dates, reason for travel, starting and ending addresses and whether it was a round trip. Other reimbursable expenses include meals and lodging while traveling for treatment, co-pays, deductibles, medical supplies and other treatment-related expenses not covered by insurance.

Contact **katie@mountainfamilycenter.org** with any questions.

Cancer-Related Services Program Application

INSTRUCTIONS: Please complete the entire application and sign your name.

Mountain Family Center is a 501(c)(3) non-profit organization. Programs are funded entirely through grants and donations. The grants that fund this program require documentation of the following information for statistical and reporting purposes only. Please complete all questions # 1-20. Failure to do so may result in denial of program benefits.

1. _____ **Name**

2. _____ **Date of Application**

3. _____ **Total Number of People in your Household**

4. _____ **How Long Have You Lived in Grand County?**

5. _____ **Mailing Address: PO Box, City, Zip Code**

6. _____ **Date of Birth (Month/Day/Year)**

7. _____ **Physical Address: Street, City, Zip Code**

8. _____ **Telephone Number** _____ **Email Address**

9. Do You Have Health Insurance? ☐ Yes ☐ No

If Not, Would You Like Help Applying For Coverage? ☐ Yes ☐ No

10. What is your cancer diagnosis or what has prompted the need for screening?

11. Please List Everyone Living in Your Household

Last Name	First Name	Date of Birth	Gender	Race *	Ethnicity *

***Race Categories:** a. American Indian/ Alaskan Native b. Asian c. Black or African American
d. Native Hawaiian / Other Pacific Islander e. White

***Ethnicity Categories:** a. Hispanic or Latino b. Not Hispanic or Latino

12. Ethnicity of Applicant (Please Complete Both Ethnicity and Race of Applicant)

☐ Hispanic / Latino **OR** ☐ Not Hispanic / Latino

13. Race of Applicant (You May Check More Than One, if Applicable)

☐ White ☐ African American ☐ Asian ☐ Other

☐ Native Hawaiian & Other Pacific Islander ☐ American Indian & Alaskan Native

14. Gender of Applicant, if Adult

☐ Female ☐ Male

15. Are You Employed? ☐ Yes ☐ No **If So, Where*?** _____

* This info helps us prove the program value to the employers in the county, which helps us get program funding and donations.

16. Applicant's Highest Grade or Level of Education

☐ Grades 0-8 ☐ Grades 9-12 / Non-graduate ☐ High School Graduate / GED

☐ 12+ Some College ☐ 2-4 years College Graduate ☐ Some Graduate school ☐ Graduate degree

17. Please Tell Us About Your Housing Situation

☐ Own our home ☐ Rent our home ☐ We do not have a home / homeless ☐ Other

18. Please Tell Us About Yourself

☐ Single ☐ Married ☐ Divorced ☐ Widowed

19. Household Financial Information (See Next Page)

20. Signature/Confidentiality Agreement

I certify (promise) that all information on this application is true and that all income is reported. I understand that officials may verify (check) the information. **I understand that if I purposely give false information, I may lose access to any of Mountain Family Center's programs and I may be prosecuted.**

Signature _____ **Date** _____

Household Financial Information	
EXPENSES	**INCOME**
Rent/Mortgage	**Salary/Wages**
- Monthly Rent/Mortgage:	- Household Member #1:
- Renter's/Homeowner's Ins.:	- Household Member #2:
- Property Taxes:	- Other:
- Property Repair/Maint.:	- Other:
Utilities	**Worker's Compensation:**
- Gas:	**Disability Pay:**
- Electric:	**Unemployment:**
- Firewood:	**Alimony/Child Support:**
- Water:	**Social Security**
- Trash:	- SSI:
- Sewer:	- SSDI:
Telephone:	- SS (Survivor's Benefits):
- Internet/Cable/Satellite TV:	
- Food:	**TOTAL MONTHLY INCOME:**
- Clothing:	**TOTAL MONTHLY EXPENSES:**
Auto	**MONTHLY EXCESS/SHORTFALL:**
- Car Payment:	
- Insurance:	
- Repairs/Maintenance:	
- Gasoline:	
- License/Registration:	
Medical	
- Insurance:	
- Co-Pays/RX:	
- Bills:	
Child-Related	
- Child Care:	
- Tuition:	
- Uniforms:	
- Books/School Fees:	
- Child Support:	
Credit Cards	
- CC #1:	
- CC #2:	
- CC #3:	
Other Expenses	
- Expense #1:	
- Expense #2:	

Cancer-Related Services Program Confidentiality Agreement

The following is a confidentiality agreement to allow the MOUNTAIN FAMILY CENTER staff to share with each other and other agencies whatever essential information about your case that might be helpful in getting resources to meet your personal needs. Any information given will be given without discrimination and with discretion of your rights.

PERSONAL IDENTIFYING INFORMATION (such as Social Security Number) WILL NOT BE COLLECTED OR DISSEMINATED to any agency.

I hereby give my permission to any duly authorized representative of MOUNTAIN FAMILY CENTER to supply information or to request information from other persons, agencies, or institutions pertaining to me or my family.

I release the MOUNTAIN FAMILY CENTER of any and all liability for supplying or requesting such information. This shall be in effect until I state in writing that it is no longer valid.

_____	_____
Client Name	Mountain Family Center Staff
_____	_____
Signature of Client	File Number
_____	_____
Date	Date

Mountain Family Center
P.O. Box 638
Granby, Colorado 80446
Office (970) 557-3186 · Fax (970) 557-3124
www.mountainfamilycenter.org