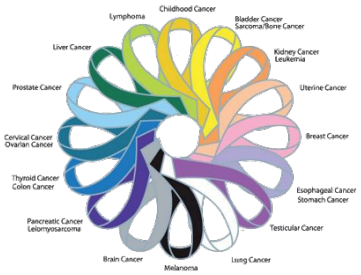



# Cancer Fund Application Checklist

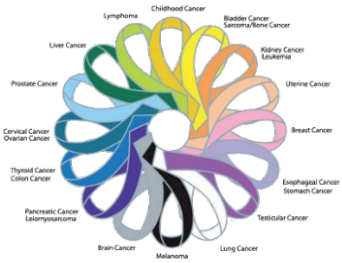
The following documents are needed to complete your application for the Cancer Fund:

- ☐ Application
- ☐ 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. (Not required for cancer SCREENING applications)

Documents can be delivered to MFC via:

- Email: katie@mountainfamilycenter.org
- Mail: PO Box 638, Granby CO 80446
- Fax: 970-557-3124 (please notify Katie if you send a fax)
- In Person: 480 E. Agate Ave, Granby CO 80446
(business hours are Mon-Thurs 9am-3pm, Fri 9am-noon)

You will be notified within 5 business days about your application approval. Once approved, you can start submitting expenses for reimbursement. Expenses can go back 12 months from date they are submitted. Each recipient is eligible for up to $5,000 for treatment-related expenses, or $1,500 for screening-related expenses. 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 $0.70/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 (trip log template available). 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.




## Cancer-Related Services Program Application

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.

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

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

**8. Gender:** ☐ Male ☐ Female

**9.** _____
**Telephone Number**

**10.** _____
**Email Address**

**11. Are You Employed (circle one)? Y N**

**12. Do you have health insurance? Y N**

**13. What is your annual HOUSEHOLD income?** _____

**14. a) Has your household income decreased as a direct result of a cancer diagnosis? (may be required to prove with pay stubs, tax documents, etc.) Y N**

**b) If you answered yes, please explain:** _____

_____

**15. Please Tell Us About Your Housing Situation**

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

**16. Please Tell Us About Yourself**

☐ Single ☐ Married/Domestic Partner ☐ Divorced ☐ Widowed

**17. Signature**

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

**Signature** _____ **Date** _____

**SEE NEXT PAGE ->**

**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 any 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.

SENSITIVE 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 | Date |
| _____ | |
| Date | |

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