Cancer of Many Colors

Small Gift Application Checklist

Date: _____

TOTAL AMOUNT REQUESTED $ _____

Patients Name: _____ **Phone:** _____

Social Worker Name: _____ **Phone:** _____

Patients Physician: _____ **Phone:** _____

Is patient currently in active treatment? **YES:** _____ **NO:** _____

DOCUMENTS TO BE INCLUDED IN PACKAGE

- APPLICATION MUST BE PREPARED, SIGNED & SUBMITTED BY SOCIAL/CASE WORKER OR DOCTOR
- PHYSICIAN LETTER STATING THAT PATIENT IS CURRENTLY ACTIVE IN TREATMENT (must be on letterhead)
- INCLUDE CURRENT BILLS THAT PATIENT IS REQUESTING HELP WITH (bills must be up to date)
- EXPENSES MUST BE FOR BASIC LIVING ONLY I.E. RENT/MORTAGE, PHONE, UTILITIES, ETC.
- PLEASE DO NOT INCLUDE MEDICAL BILLS
- BILLS MUST HAVE CLEAR NAME PAYABLE TO SERVICE PROVIDER & CORRECT ADDRESS BEFORE SUBMITTING
- IF YOU HAVE RECEIVED A SMALL GIFT FROM CMC IN THE PAST YOU ARE NOT ELIGIBLE FOR A 2ND GIFT

If request is approved, funds will be payable directly to the service provider with a maximum gift up to $500.

SCAN APPLICATION & BILLS, PLEASE EMAIL TO: INFO@CANCEROFMANYCOLORS.COM

MAIL: 100 OLD CHEROKEE RD., SUITE F - #339, LEXINGTON, SC 29072

I acknowledge that I, the patient, am a current resident of the addressed bills submitted.

_____

Patient Signature

A 501-(c)(3) NON-PROFIT ORGANIZATION

SMALL GIFT PROGRAM

Form Updated 2/6/24

DATE: _____

REQUEST FOR IMMEDIATE/EMERGENCY ASSISTANCE

COMMUNITY RESOURCE PARTNER i.e. Social/Case Worker, Doctor	RECIPIENT INFORMATION
NAME: _____	**PATIENTS NAME:** _____
JOBTITLE: _____	ADDRESS: _____
FACILITY: _____	**CITY/ST/ZIP:** _____
ADDRESS: _____	**COUNTY:** _____ **PHONE:** _____
CITY/ST/ZIP: _____	**DIAGNOSIS:** _____
PHONE: _____	**DOB:** _____ **GENDER:** _____
EMAIL: _____	**ETHNICITY:** _____
	EMAIL: _____

REQUIREMENTS:

- You must be a resident of South Carolina.
- You must provide a statement from your physician on their letterhead, stating that you are currently under active treatment/therapy. Active treatment or therapy is considered those treatments for newly diagnosed cancer or recurrence of previous diagnosed cancer. (Maintenance treatment/therapy will not be applicable for this benefit. Maintenance treatment/therapy is considered preventive drugs, routine doctor visits, labs, scans, etc. An example of preventive drugs would be femara, tamoxifen, arimidex, etc. Maintenance treatment/therapy are for those individuals who are cancer free.)
- A Community Resource Partner (CRP), such as, social/case worker or doctor must sign application certifying that you need Assistance.
- Along with the application, you must provide copies of the current bill/s that you are requesting help with. Bills must have the name of the service provider and correct address before submitting.
- All gifts are paid directly to the service provider. *CMC only assist with ***non-medical bills***. There are no age restrictions for the recipients of the gift.

TREATMENT FACILITY: _____

NAME OF PHYSICIAN: _____

Please ***describe in detail*** how will this gift impact you.

(You may attach another sheet of paper if necessary):

SMALL GIFT PROGRAM

Form Updated 2/6/24

A 501- (c)(3) NON-PROFIT ORGANIZATION

DATE:_____

SERVICES WHERE ASSISTANCE IS NEEDED

State ***exactly*** what services are needed. Please provide ***qualified*** documentation from the service provider/ company for which the patient needs assistance. ***(Qualified documentation*** *is a current invoice from business on company's letterhead.)* **If request is approved, the funds will be payable directly to the service provider with a maximum gift of up to $500.** Have you ever applied for assistance from CMC? Yes_____No_____

VENDOR / COMPANY		BEHIND	AMOUNT
1. Name: _____	# Month's	_____	$ _____
2. Name: _____	# Month's	_____	$ _____
3. Name: _____	# Month's	_____	$ _____
4. Name: _____	# Month's	_____	$ _____
5. Name: _____	# Month's	_____	$ _____

ANTICIPATED COST OF GIFT **$ _____**

I certify that the above-named patient needs immediate assistance with their basic living expenses. The patient and family are having a difficult time receiving help from their immediate family, friends and other programs. I certify all the information is true and complete to my knowledge. Cancer of Many Colors supports those burdened by a cancer diagnosis by providing temporary financial support to those needing help with their basic living expenses while going through treatment***. (NOTE: Cancer of Many Colors, Inc. does not provide continuing funding. However, exceptions can be reviewed, on a case by case basis, for an individual financial need of a basic living expense. Gift exceptions may only be granted by the Board of Director's approval.)***

COMMUNITY RESOURCE PARTNER: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

By signing the Small Gift Application, I'm giving CMC permission to discuss any billing information with the attached businesses to expedite my request for assistance. I'm also giving CMC permission to post pictures of me and a testimonial on the CMC website.* ****Electronic signature will be accepted as signed application.*

Email documents to: info@cancerofmanycolors.com (Include application, physician statement & copy of expenses for faster turnaround time. Sent via US Post Office takes longer.)

BUSINESS HOURS:

Office Hours are Monday – Friday from 9:00 am to 5:00 pm; After 5:00 pm please leave message with answering service. Weekend contact by email or answering service only. Closed for holidays. If emergency please leave message with answering service.