WWW.ELEV8CURE.ORG

Submission Check List

These documents are required to be submitted for eligibility.

_____ Medical Information Form

Must be completed and signed by health care professional

_____ Patient Information Form

_____ Patient Release Form

Must be signed by patient

Optional and Additional Check List

These documents are not required to be submitted for eligibility but may help our grant review committee have a better idea of the applicants need. We encourage you to submit these documents, however they are not required.

_____ Letter from applicant explaining cancer diagnosis and why the grant/support is needed

_____ Photo of applicant

Submit application by mail or email to the following locations

Elev8Cure Foundation
6667 NE Windermere Rd.
Seattle, WA 98115
OR
Email: grants@elev8cure.org

Elev8Cure Foundation requires that an applicant work with a social worker or health care professional to help them complete our application for financial assistance. The health care professional or social worker will also serve as our main contact if questions arise regarding the patient's application.

General Grant Requirements

- Patient must be living in the United States.
- Patient must be 18 years or older. Parental consent is required for patients younger than 18.
- Patient must have a cancer diagnosis verified by an Oncologist
- Patient must meet financial guidelines set by Elev8Cure Foundation.
- Patient is able to receive one general grant through Elev8Cure Foundation.

What Elev8Cure will cover:

Here is an overview of Elev8Cure Foundation procedures. Please contact us if you have any questions or concerns.

Elev8Cure Foundation Grant Procedures:

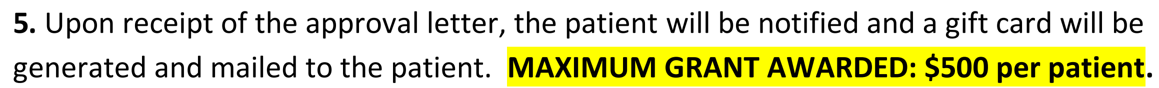
1. The Medical Information Form and top portion of the Patient Information form needs to be completed by a social worker or health care professional. An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to verify the patient has cancer and is currently undergoing treatment by signing the Medical Information Form. Do Not Send your Medical Records.

2. The Patient Information Form and Release Form need to be completed by the patient, including the patient's signature.

3. Please mail or email the completed paperwork to the address/email listed on the cover page. Once the application has been processed, Elev8Cure Foundation will contact the patient, social worker or health care professional via mail, phone or email to inform them of the grant details.

4. All pages of the application must be completed in order to be processed. Incomplete applications will be returned for completion and will not be reviewed until a completed application is submitted.

5. Upon receipt of the approval letter, the patient will be notified and a gift card will be generated and mailed to the patient. **MAXIMUM GRANT AWARDED: $500 per patient.**



6. Elev8Cure Foundation has a quarterly grant spending limit and will review applications on a first some first serve basis.

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ELEV8CURE FOUNDATION PATIENT SUPPORT APPLICATION FORM

Patient Information:

First Name: ______________________________ Last Name: ____________________________

Date of Birth: _______________ Gender: M _____ F _____

Marital Status: ________________

Diagnosis: ____________________ Stage: __________ Date of Diagnosis: _________________

Current Treatment (check all that apply)

_____ Chemotherapy Date of Last Treatment: _________________

_____ Radiation Date of Last Treatment: _________________

_____ Bone Marrow Transplant Date of Last Treatment: _________________

_____ Surgery Date of Last Surgery: _________________

_____ Palliative Care Date Entered: _________________

_____ Chemotherapy Date Entered: _________________

TO BE SIGNED BY TREATING ONCOLOGIST, REGISTERED ONCOLOGY NURSE, OR LICENSED MEDICAL SOCAIL WORKER

I attest the patient has/had cancer and is/was treated as stated above

X____

Please inform us why the patient is in need of Financial Assistance (REQUIRED):

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Clinic Information:

Clinic:__________________________________Oncologist:______________________________

Address:____City:________________________

State:________Zip:_________________Phone: (_______)_______-__________________

Social Worker/Health Care Professional Information:

Name:_____________________________Phone: (_______)________-_____________________

Clinic/Organization:____

Address:____

City:______________________State:________Zip:_________Fax: (_______) _____-__________

Email: ____

*Information regarding the qualifying amount for this patient will be emailed to you

PATIENT INFORMATION FORM

Patient Information:

First Name:____________________Last Name:___________________________________
Address:____________________________________City:___________________________
State:_______Zip:________County:__________________Phone:_____________________
Email:____
Is okay to leave a message on your phone? Yes No
Inform me regarding my application via_____Email or_____Mail
Responsible Party (If different than above)
First Name:____________________Last Name:__________________________________
Address:___________________________________City:_ State:
____________Zip:________County:__________________Phone:____________________
Email:_____________________________Relationship to patient:_________________
Please list the people in your household

Name	Date of Birth	Relationship

PATIENT RELEASE FORM

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Elev8Cure Foundation. I hereby give my permission that this application and all information provided can be sent to Elev8Cure Foundation and discussed with my health care professional. All information reviewed is confidential.

Patient Signature:_____________________________________Date:_____________

Print Name:____

Please take some time to answer the questions below

I would like to be on Elev8Cure Foundation's mailing list?_ _

Yes____No

How did you hear about Elev8Cure Foundation?

_________ Social Worker Name: ____

_________ Nurse Name: _______________________________________

_________ Oncologist

_________ Patient Financial Counselor

_________ Patient Navigator

_________ Friend Name:_______________________________________

_________ Internet

_________ Brochure

_________ Other:____

Please provide additional comments regarding your situation that might be helpful when reviewing your application. If needed, please attach a letter explaining further your financial hardship.

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___________________________ (Attach additional page if needed)

All applications are kept confidential. Elev8Cure Foundation cannot meet every request, however some assistance is generally available. Families may be prioritized by need. Elev8Cure Foundation reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

Financial assistance is only available to US residents only.