



Rock County Cancer Coalition

Application Instructions

Applicant Name _____ Date _____

THIS FORM, AND EVERYTHING LISTED BELOW, MUST BE INCLUDED WITH YOUR COMPLETED APPLICATION PACKET TO BE CONSIDERED FOR A GRANT

Please do not send originals of your personal information.

Reminder: you must be in active treatment for your application to be considered.

1. _____ **COPY OF CURRENT DRIVER'S LICENSE OR STATE ID:** Provide a copy of your current driver's license or state identification card for proof of residency
2. _____ **COPIES OF BILLS/EXPENSES:** *We need your help to prove that you need our help!*
Required: You must include a current copy of each bill/expense that you are asking assistance with: RCCC helps with essential bills such as rent/mortgage, utilities, phone bill, car payment.
3. _____ **REQUEST FOR ASSISTANCE FORM** - MUST be completed and signed
4. _____ **DIAGNOSIS VERIFICATION FORM and TREATMENT STANDARD FORM**
Give this to your doctor to complete and sign.
5. _____ **AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**
6. _____ **RCCC SIGNED APPLICATION-** Make sure it is all filled out and signed!

Rock County Cancer Coalition PO Box 2092 Janesville, WI 53547
For any questions, please call RCCC at 608-754-2286

Rock County Cancer Coalition Application

Name _____ Phone (____) _____

Address _____ Age _____ Birth Date _____

City _____ Zip Code _____

Married ___ Single ___ Children Yes No Ages _____

Oncologist _____ Phone (____) _____

Clinic/Hospital _____

Type of cancer _____

Should RCCC need to contact you for any reason, please provide name and phone number of additional contact to act on your behalf should we not be able to reach you directly:

Contact Name/Phone _____

How did you hear about Rock County Cancer Coalition? _____

Case Manager/Cancer Navigator (State/Name/Phone #) _____

Medical Professional (State/Medical Facility) _____

Is this the first time you have applied for assistance from RCCC

___ Yes

___ No - If no, when was the last time you applied for or received assisted from RCCC _____

******Reminder you MUST be CURRENTLY in an active treatment of cancer and have not been funded by RCCC within the last 12 months******

I verify that I currently am living **FULL TIME** in Rock County, Wisconsin. That I am actively seeking treatment in a fact based, clinically proven cancer treatment and receiving treatment at least every 3 months. I am requesting assistance from Rock County Cancer Coalition

_____ Date: _____

(Applicant's signature)

Applications are reviewed and acted upon approximately within 30 days of RCCC receiving the application. You should continue to pay your bills and RCCC is not liable for any late payments.