ROCK COUNTY CANCER COALITION

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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

Last Updated Nov 8, 2021

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Rock County Cancer Coalition Application

Name _____Phone (_____) _____
Email_____
Address_____City _____ Zip _____
Age_____ M or F Birth Date _____
Married____ Single____ Children Yes No Ages_____

Oncologist_____Phone (____) _____
Clinic/Hospital _____Type of cancer _____

Please provide name and phone number of *additional contact* to act on your behalf should we not be able to reach you directly: Name/Phone _____

How did you hear about Rock County Cancer Coalition?
Case Manager (Name/Phone #) _____
Medical Professional (State/Medical Facility) _____
Other_____

Is this the first time you have applied for assistance from RCCC? (Circle one) YES or NO
If NO: When was the last time you applied for or received assisted from RCCC_____

Since you started receiving cancer treatments, would you say that the financial obligations associated with your treatments have: **(circle one)** **a**. Not caused you any stress **b.** Caused you slightly increased stress
c. Caused you significantly increased stress

******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)

Sharing stories and testimonials, often assists in raising funds and awareness for RCCC. Would you or a family member be willing to offer your testimonial as to how the RCCC Grant affected your life? If so, *thank you* and please include yours and/or your family members name/email address.

_____
(In no way, does your answer affect your application approval)

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.

Last Update Dec 1, 2021