Rock County Cancer Coalition

Application Instructions

Applicant Name_____**Date**_____

ALL 5 PAGES MUST BE <u>COMPLETED AND INCLUDED</u> TO BE CONSIDERED FOR A GRANT

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

1.___**COPY OF CURRENT DRIVER'S LICENSE OR STATE ID:** For proof of residency

2.___**COPIES OF BILLS/EXPENSES**: Include a copy of up to three bills. The address on the bill must match the address on your driver's license/ID

3.___**REQUEST FOR ASSISTANCE FORM**

4.___**DIAGNOSIS VERIFICATION FORM and TREATMENT STANDARD FORM** Give this to your oncologist to complete (MD,NP,PA)

5.___**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

6.___**RCCC SIGNED APPLICATION**

7.___ALL 5 PAGES, COPIES OF BILLS AND COPY OF ID

Rock County Cancer Coalition PO Box 2092 Janesville, WI 53547
For any questions, please call RCCC at 608-754-2286 or Email: Info@Rockcountycancercoalition.org

FOR OFFICE USE ONLY

CASE # DATE

DESCRIPTION OF SUPPORT	CHECK #	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last Updated 04/05/24

ROCK COUNTY CANCER COALITION
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Application

Name _____ Phone (_____) _____

Address_____ City _____ Zip _____

Email_____ Birth Date _____Age_____

Race: (circle one) Asian Black/African American Hispanic/Latino Multi-Racial Native American White/Caucasian
Other:_____

Gender: (circle one) Female Male Transgender Non-Conforming

Oncologist_____Type of cancer _____

Clinic/Hospital _____Phone (_____) _____

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 the Rock County Cancer Coalition _____

Is this the first time you have applied for assistance from RCCC? (Circle one) YES NO

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

I verify that I am currently living in Rock County, WI **full time**, that I am in active treatment for cancer, and I have not received financial assistance through RCCC in the last 12 months

_____ Date: _____
(Applicant's signature)

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

ROCK COUNTY CANCER COALITION
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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____
Name of Patient/Previous Names | Birth Date/Medical Record Number

_____ _____
Street Address | City, State, Zip Code

AUTHORIZES DISCLOSURE TO:
Rock County Cancer Coalition, Inc
PO Box 2092
Janesville, WI 53547

AUTHORIZES DISCLOSURE BY:

_____
Name of Health Care Provider
Address _____
City, State _____
Zip _____

INFORMATION TO BE DISCLOSED:
Verification of current diagnosis related to cancer or treatment related to cancer.

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through Rock County Cancer Coalition, Inc.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or receive a copy of the Health Information to be used or disclosed – I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization – I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization – I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. The consequence of not signing the authorization form would be that information will not be disclosed. Right to withdraw this authorization – I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: This authorization is good for 90 days from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____Date:_____
(If signed by other than patient, state relationship and authority to do so)

ROCK COUNTY CANCER COALITION
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Diagnosis Verification Form

Treatment Standard for your *Oncologist to Complete* (MD,NP,PA)

Applicant's Name: _____

Type of cancer applicant is diagnosed with _____

In order to be considered for a financial grant applicants MUST be in active treatment for a cancer diagnosis. Active treatment does NOT include surveillance, or hormone therapy. Oral chemotherapy will be reviewed on a case by case basis.

What treatment(s) is the applicant currently receiving?

☐ **Chemotherapy** **Choose one/both** ☐ **IV** ☐ **Oral - Name of medication**_____

☐ **Radiation**

☐ **Surgery - Date and suggested surgical recovery period**_____

Form can be completed by MD,NP,PA, but must be signed by the Oncology Physician

Name of person completing this form:_____**Direct Phone**_____

Oncology Provider Signature: _____ **Date:** _____

Oncology Provider name printed: _____

Hospital/Clinic Name:_____

Phone Number:_____

Form Updated 04/05/24

Rock County Cancer Coalition Request for Assistance

Name _____ DOB _____

You must include a **copy of each bill/expense** that you are asking assistance with (Address must match ID)

RCCC will write the check to the company and mail the checks to you to send out with your payment.
Continue to pay your bills on time as we cannot guarantee when the checks will be processed.
You may request amounts that are higher than what is due on your bill.
Your company will credit your account. Please choose no more than 3 separate bills for us to pay.
$1400.00 benefit limit per client. Please round up your dollar amount to the nearest $5 increments.

I am requesting assistance with the following bills:

Rent/Mortgage
Company Name: _____
Amount Requested: _____

Phone Bill
_____
_____

Water/Sewer Bill
Company Name: _____
Amount Requested: _____

Electric/Gas/Propane Bill
_____
_____

Car Insurance
Company Name: _____
Amount Requested: _____

Health Insurance Premium
_____
_____

Car Payment
Company Name: _____
Amount Requested: _____

Due to ongoing problems with Charter and Spectrum, RCCC can no longer pay those bills for our clients.

Please make sure that the total amount of assistance does not exceed $1400.00 if requesting more than one bill to be paid.

_____ 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.

Last Revised 04/05/24