

Rock County Cancer Coalition Grant Application Instructions

Applicant Name _____ **Date** _____

RCCC reserves the right to update application requirements and grant limits at any time. Only the most current version of the application will be accepted: visit www.rockcountycancercoalition.org/how-do-i-get-help/.

Please review the application carefully to avoid delays in processing. For questions, please call RCCC at 608-754-2286 or Email: info@rockcountycancercoalition.org

**You must be in active treatment and reside in Rock County, WI
for your application to be considered**

ALL 5 PAGES MUST BE COMPLETED AND INCLUDED TO BE CONSIDERED FOR A GRANT

1. ___ Application Instructions (**Page 1 of 5**)
2. ___ Rock County Cancer Coalition Application (**Page 2 of 5**)
3. ___ HIPAA Authorization For Disclosure of Health Information (**Page 3 of 5**)
4. ___ Diagnosis Verification Form Oncologist to Complete (MD, NP, PA) (**Page 4 of 5**)
5. ___ Rock County Cancer Coalition Request for Assistance (**Page 5 of 5**)
6. ___ Photocopy of Current Driver’s License or State ID (*proof of residency*)
7. ___ Photocopies of Bills/Expenses:
 - a. Include bills for up to three (3) payees (whom the check is written to)
 - b. The bills must show the account number
 - c. The address on the bill must match the address on your driver's license/ID

Original application and documentation is required.

We DO NOT accept emailed or faxed copies.

Mailing Address

Rock County Cancer Coalition
PO Box 2092
Janesville, WI 53547

Drop in Person

One Parker Place
Suite 320
(slide under the door)

FOR OFFICE USE ONLY

| | | |
|------------------------|----------------|-----------------|
| CASE # | DATE RECEIVED: | DATE PROCESSED: |
| DESCRIPTION OF SUPPORT | CHECK # | AMOUNT |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Rock County Cancer Coalition Grant Application

This section is **required**.

Name _____ Phone (_____) _____

Address _____ City _____ Zip _____

Email _____ Birth Date _____ Age _____

Name and Phone Number of Additional Contact to Act on Your Behalf: _____

Oncologist _____ Type of cancer _____

Clinic/Hospital _____ Phone (_____) _____

Have you applied for assistance from RCCC in the past? (Circle one) YES NO

How did you hear about the Rock County Cancer Coalition? _____

This section is **optional**, however your response helps us better serve our community, qualify for grants that support our mission, and continue to offer support to patients in Rock County, WI.

➤ Race: (circle one)

- a. Asian
- b. Black or African American
- c. Native American
- d. Latinx
- e. White
- f. Other (please specify) _____
- g. Decline to State

➤ Gender: (circle one)

- a. Female
- b. Male
- c. Transgender
- d. Non-Binary
- e. Other (please specify) _____
- f. Decline to State

I certify that I am a full-time Rock County, WI resident, currently in active cancer treatment, and have not received RCCC financial assistance in the past 12 months.

Applicant's signature: _____ Date: _____

Please continue to pay your bills. RCCC is not liable for any late payments.



HIPAA Authorization For Disclosure Of Health Information

PATIENT INFORMATION:

Name _____

Date of Birth _____

Street Address _____

City, State, Zip Code _____

AUTHORIZES DISCLOSURE TO:

Rock County Cancer Coalition, Inc.
PO Box 2092
Janesville, WI 53547

AUTHORIZES DISCLOSURE BY:

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.

This authorization is valid for 90 days from the date signed. I certify that I have had the opportunity to review and understand the content of this authorization form.

SIGNATURE OF PATIENT/LEGAL REP: _____ **Date:** _____

If signed by other than patient, state relationship and authority to do so: _____

Diagnosis Verification Form Oncologist to Complete (MD, NP, PA)

Applicant Name: _____

Cancer diagnosis with ICD10 Code + Stage _____

Current Treatment Status

- Active cancer-directed treatment
- Maintenance/long-term therapy (ONE-TIME GRANT)
- Monitoring/surveillance only (NOT ELIGIBLE)
- No current treatment (NOT ELIGIBLE)

Current treatment(s) being received (Check all that apply)

- IV Chemotherapy
- Oral Chemotherapy
- Immunotherapy
- Hormonal/Endocrine Therapy
- Targeted Therapy
- Radiation
- Surgery
- Clinical Trial
- Other: _____

Surgery Information (if applicable)

Surgery Date: _____

Expected recovery time: _____

This form can be completed by MD, NP, PA, but MUST be signed by the Oncology Physician.

Person completing this form _____ Direct Phone _____

Oncology Provider Signature _____ Date _____

Oncology Provider name printed _____

Hospital/Clinic Name _____

Direct Phone Number for Provider Office _____

Rock County Cancer Coalition Request for Assistance

Applicant Name _____ DOB _____

Please read the following information carefully to avoid any delays in processing.

Required Documents

- Include a copy of each bill/expense submitted. Bills must be less than 90 days old.
- Submit no more than three (3) bills per application.
- Each bill must include a complete account number. Partial information will not be accepted.
- The address on the bill, mortgage, or lease must match the address on your driver's license or ID.

We do not accept requests for the following bills: Medical Bills, Charter, Spectrum, American Family Insurance, Credit Cards.

Payment Information

- RCCC issues checks payable to the company and mails them to the applicant. Applicants are responsible for forwarding payments to the company.
- Please continue making payments on your bills, as RCCC cannot guarantee processing times or payment dates.
- You may request more than the amount currently due. The company may apply the remaining balance as a credit to your account or reduce your principle.
- Round all requests to the nearest \$5.

Grant Eligibility

- The current grant amount is \$1,000.
- Applicants receiving active cancer-directed treatment may qualify for one (1) grant every 12 months.
- Applicants receiving maintenance or long-term therapy that is not considered active cancer-directed treatment may qualify for a one-time assistance grant.
- Assistance is dependent on available funding. Submission of an application does not guarantee approval or payment.

#1 Company Name _____ Amount Requested \$ _____

Type of Assistance: Rent/Mortgage Utilities Insurance Other

#2 Company Name _____ Amount Requested \$ _____

Type of Assistance: Rent/Mortgage Utilities Insurance Other

#3 Company Name _____ Amount Requested \$ _____

Type of Assistance: Rent/Mortgage Utilities Insurance Other

Applicant Signature _____ Date _____

Please continue to pay your bills. RCCC is not liable for any late payments.



CANCER SUPPORT GROUP



HELD THE 2ND AND 4TH TUESDAY OF THE MONTH
6:00 pm - 7:00 pm
One Parker Place Suite 408

We are a cancer support group for anyone newly diagnosed, currently receiving treatment and survivors of cancer.

Our mission is to create an atmosphere to help each other along the cancer journey through giving and receiving of emotional support, sharing of knowledge and building a strong network of support and love through open discussion and activities.

FOR RCCC SUPPORT GROUP QUESTIONS:

Goli Ziolk - Executive Director for RCCC
RCCCSupportGroup@rockcountycancercoalition.org

RCCC follows the federal COVID-19 guidelines and you should protect yourself if you have weakened immune systems.

**TO LEARN ABOUT ROCK COUNTY CANCER COALITION
SCAN HERE AND GO DIRECT TO OUR HOME PAGE**
www.rockcountycancercoalition.org



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