Applicant Name ________________________

DOB __/__/____

Family Cancer Network Financial Grant Request Application

What is the Family Cancer Network Financial Grant Program?
The Financial Grant Program is available for qualified, blood cancer patients, with significant financial need, to help with ancillary expenses such as transportation/travel, prescriptions, or expenses due to lost wages and all other non-reimbursed medical expenses incurred while in treatment. A grant is available for qualified patients.

Program Criteria:
1. Applicant (patient) must be a US citizen and permanent resident of Iowa, which is verified by applicant's physical address;
2. Applicant must have a confirmed diagnosis of blood cancer; and
3. Applicant may be insured or uninsured.

STEP 1:

1. Are you in current treatment for a blood cancer? Yes_____ No _____

2. Are you a United States citizen? Yes_____ No _____

   Do you have a lawful green card or immigrant visa? Yes_____ No _____

3. Have you been a resident of Iowa for 12 months or longer? Yes_____ No _____

   When did you become a resident of Iowa? ____________________

All applicants must be prepared to provide documentation to verify Iowa residency upon request and verification of illness. If you have any questions regarding these requirements, please contact us at

Grants@FCNet.org

FAMILY CANCER
NETWORK

Step 2:

This application must be completed in its entirety and signed by both
the patient (parent/guardian) and the patient's physician

Patient Information

Patient First and Last Name: ____

If patient is less than 18 years of age, please also provide parent/guardian first and last name:

____

Gender: ☐ Male ☐ Female

Address: ____ Apt. #________

City/State/ZIP: ____

Country (if military): ______________________________

Email: ____

Home Phone: ___________________________ Work Phone: ___________________________ and/or

Cell Phone: _____________________________

How did you hear about the BSB Financial Grant?

(Please Circle) Doctor Nurse Social Worker Friend/Family member Other (please specify): _______

____

Applicant Name ________________________

DOB / /

FCN Financial Grant Request Application Cont'd

Medical Information

To be completed by the patient's prescribing healthcare provider or designee. Please note, stamps or initials will not be accepted.

Patient Diagnosis/Subtype: ____

Date of Diagnosis: ___________________ Is patient in active treatment and/or ongoing follow-up? ☐ Yes ☐ No

Healthcare Provider Name: ______________________________

Hospital/Clinic: _______________________________________

Designee Name/Title: ____

Address: ____________________________________ City/State/ZIP: ___________________________________

Care provider contact phone number: _______________________

Healthcare Provider License #: _______________________________

I authorize my Healthcare provider to release verification of my illness to a representative from Blood Sweat and Beers Iowa. Yes______ No________

Patient/Guardian Signature ____

Applicant Name ___________________________

DOB __/__/____

Health Insurance Information

Do you currently have health insurance? ☐ Yes ☐ No. If yes, please circle all that apply:

Medicare Part B: Medicare Part D: Medicaid: Health Exchange Plan: Commercial: Other (if other, please specify) ____

Household Financial Information

Number of people in the household: _____________ Is the patient/guardian currently employed? ☐ Yes ☐ No

Current annual household income: ____________________________

Patient's Explanation on need/use of Funds:

Please provide as much detail as possible to help in our decision

____

____

____

____

____

____

____

____

____

____

Continue on Next Page

Applicant Name ________________________

DOB __/__/____

Patient's Explanation on need/use of Funds:

____
____
____
____
____
____
____

Grant Request Amount

□ $250 □ $500 □ $750 □ $1000 □ other _________

Patient Signature & Attestation

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate, and if asked, I agree that I can, and will, provide documentation.
I further authorize the release of this information to the Family Cancer Network committee.
I further attest that if approved for a financial grant, the funds will be used for treatment transportation/travel, expenses due to lost wages and/or for other non-reimbursed medical expenses.

Patient/Guardian Print Name: ____
Patient/Guardian Signature: ____Date: _____/_____/______

This program is provided by a grant from Family Cancer Network for use on an individual basis and availability of funds, verification of need and verification of illness.