Cost of Cancer Grant Application

Application Date: _____

Grant Applicant name: _____

E-mail _____

Date of Diagnosis _____ Stage _____ Disease type _____

Date of last treatment _____

Total Amount Requested *($500 limit)* $ _____

Brief Description of Use

_____

Medical Personnel Verification

Name _____ Organization _____

Phone _____

I verify that the patient named on this form is in treatment for colorectal cancer or has completed treatment in the last 6 months from the date on this application.

Signature of Medical Personnel _____

Please make payment to the following vendor(s.) A one-time payment will be made to the vendor(s) after this grant has been approved.

Name _____ Company _____ Phone and E-mail _____

Address _____

Account number _____ Amount: $500 limit _____ Check memo _____

Name _____ Company _____ Phone and E-mail _____

Address _____

Account number _____ Amount: $500 limit _____ Check memo _____

Email completed form to: info@coloncancercoalition.org

Privacy + Use Statement *– The Colon Cancer Coalition / Get Your Rear in Gear, reserves the right to use information from applicant for promotional purposes. In such cases, the identity of the grantee will remain anonymous.*

ACKNOWLEDGMENT AND CONSENT
FOR USE IN DISCLOSURE OF HEALTH INFORMATION

*You may refuse to sign any part of this form.

You may request a copy for your files.

Please read the following statements carefully in bold:

Purpose of Acknowledgment and Consent.

By signing this form, you will be allowing us to view protected health information in order to provide grant money to assist in the payment of your colorectal cancer care.

It is not our intent to use or disclose any of your protected health information for any other purpose other than to verify your eligibility to receive grant funds.

You will have the right to revoke this Acknowledgment and Consent at any time by giving our office written notice of your revocation.

Please understand that revocation of the Acknowledgment and Consent will not affect any action that was taken in reliance upon this Acknowledgment and Consent before we received your revocation, and we may decline to continue to provide grant money for your benefit if you revoke this Acknowledgment and Consent.

ACKNOWLEDGMENT OF RECEIPT OF ACKNOWLEDGMENT AND CONSENT

I, (please print) _____, have had full opportunity to read and consider the contents of this Acknowledgment and Consent form and I understand that by signing this Acknowledgment and Consent form, I am giving my acknowledgment and consent to your use of my protected health information to confirm eligibility and carry out grant payment activities on my behalf.

_____ _____ _____

Signature Date Address

*If this Acknowledgment and Consent is signed by a personal representative on behalf of the patient, complete the following representative (please print):

_____ _____

Representative Printed Signature Relationship to Patient