CANCER COALITION
OF SOUTHWEST COLORADO

GRANT FUNDING GUIDELINES
FOR INDIVIDUALS WITH CANCER

Description

The Cancer Coalition ***of Southwest Colorado (CCSWC)***, a volunteer group that raises funds and uses them to assist individuals in cancer treatment, will provide an annual grant of up to **five hundred dollars ($500.00)** in funding for qualifying individuals with cancer. Funding is based on availability of coalition funds and eligibility based on established applicant criteria listed below through a formal application process. Funds are available for **non-medical expenses only**. Individuals may receive a grant one time (non-renewable).

Requirements

Residency

The applicant must reside in Southwestern Colorado in Archuleta, La Plata, or San Juan County. Grant applications for Dolores and Montezuma County will be reviewed by the Cancer Resource Alliance from those counties. Grant applicants from New Mexico should contact San Juan Cancer Center Nurse Navigator.

Medical

The applicant must be currently in treatment or have completed treatment within the past three months...

Financial

Total household income at the time of application may be equal to or less than $50,000 annual income. If income exceeds this amount and you feel there are special circumstances regarding your current status, please attach a letter of explanation and your request will be considered. Current monthly total household income will also be considered. Total household income includes, but is not limited to, such income as all wages, retirement pension, alimony, worker's compensation, Social Security, and employer disability insurance.

Review Process

Review of applications will be conducted by at least two members of the Cancer Coalition of Southwest Colorado. Applications will be reviewed and processed within two weeks of receipt.

Privacy

The coalition will maintain confidentiality of information provided on the application. The applicant must specify on the application the requested method of contact by the coalition review committee or any other individuals involved in your care such as family, friend or caretaker that the coalition may contact.

Distribution of Emergency Funds

The individual applicant will be contacted when the application arrives and a review process by a committee will take place. Upon approval of a grant, checks are written by Community Foundation, fiscal sponsor for CCSWC, and mailed to the recipient's home or PO Box. If Gas cards are requested and approved, distribution will be made on a weekly basis through the Durango ACS Cancer Resource Center. One must call ahead to request these (970-403-0086). None will be mailed. Gas cards are considered a part of the full financial grant.

Revised: 1/2018, 9/2018, 7/2019, 3/2020

CANCER COALITION
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APPLICATION FOR NON-MEDICAL EXPENSES
CANCER COALITION of SOUTHWEST COLORADO GRANT

PATIENT INFORMATION (PLEASE PRINT CLEARLY AND COMPLETE IN ENTIRETY!) READ THE GUIDELINES ON THE REVERSE SIDE FOR FURTHER INFORMATION. PLEASE ATTACH A NOTE FOR ANY CLARIFICATION.

DATE _____

First Name_____Last Name_____

Address (Street)_____

(City)_____(State)_____ (zip code) _____

Mailing address if different_____

Home Phone _____Cell phone _____

Date of Birth _____ Marital Status _____

#in household_____ #children in household_____

Total Annual Household Income _____Monthly Income_____

Cancer type _____In treatment now? _____

Date treatment started? _____Date Treatment Completed?_____

Have you ever received a CCSWC grant in the past? _____If yes, when? _____

HEALTH CARE PROVIDER OR REFERRING INDIVIDUAL INFORMATION:
(physician, nurse practitioner, physician assistant, nurse or social worker)

Name_____Position_____

Facility_____ Telephone _____

Health Care Provider/Referral Signature _____Date_____

REQUESTED FUNDING INFORMATION

Please indicate for which item you are seeking funding.

Utilities _____Groceries _____Car payment _____ Rent _____ Mortgage_____

Gas Cards _____ Other non-medical emergency needs _____

How did you hear about us?

_____ Durango Cancer Center _____ CCSWC brochure _____ACS Cancer Resource Center

_____ Friend _____ Other

Patient Signature _____Date_____

By signing this form, I am consenting to disclosure of information on this application to the Cancer Coalition of SW CO and exchange of information between my health care provider or referring individual and the Cancer Coalition as relevant to this application process.

Submit your application to:

Cancer Coalition of Southwest Colorado, P.O. Box 1455, Durango, CO 81302 telephone: 970-799-1654

Revised: 1/2017, 10/2018, 7/2019, 3/2020