Colon Cancer Prevention Project

The Fighters' Fund

The Colon Cancer Prevention Project -- helping you cope.

ABOUT THE FUND

The Fighters' Fund is a financial assistance program that provides one-time grants of $200 to qualifying patients based on need.

Applicants must meet all of these qualifications:

- Be a resident of Kentucky; or Floyd or Clark Counties in Southern Indiana.
- Be receiving treatment for colon or rectal cancer.
- Have never received a grant from the Colon Cancer Prevention Project's Fighters' Fund.

Grants are awarded based on need and available funding. Grants are considered on a quarterly basis. For a grant to be considered during a particular quarter, the Colon Cancer Prevention Project must receive this application by that quarter's deadline (see list below).

Application Deadlines

1st quarter: Applications accepted Jan. 2 – April 1
2nd quarter: Applications accepted April 2 – July 1
3rd quarter: Applications accepted July 2 – Oct. 1
4th quarter: Applications accepted Oct. 2 – Jan. 1

All applicants will be notified by mail once the review process is complete. The review committee meets quarterly and notifications are mailed within 45 days of the quarter's deadline. Applicants who qualify for a grant but do not receive one are welcome to reapply.

HOW TO APPLY

To apply, fill out this form completely and mail to:

Colon Cancer Prevention Project
PO Box 4039
Louisville, KY 40204

Applications are also available at www.ColonCancerPreventionProject.org.
For more information, contact the Colon Cancer Prevention Project: (502) 290-0288 or (800) 841-6399.

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The Fighters' Fund Application

Applications will not be shared except with The Fighters' Fund Grant Approval Committee and Colon Cancer Prevention Project staff. **PLEASE PRINT CLEARLY.**

Are you a resident of Kentucky; or Floyd or Clark County in Southern Indiana?

- ☐ Yes
- ☐ No

Have you ever received a grant from the Colon Cancer Prevention Project?

- ☐ Yes
- ☐ No

DEMOGRAPHIC INFORMATION

Name: _____

(First) (M.I.) (Last)

Address:

_____

(Street Address)

_____

(City) (State) (Zip)

Phone Number: (_____)_____

Alternate Phone Number: (_____)_____

E-mail: _____

Gender:

- ☐ Male
- ☐ Female

Date of Birth (day/month/year):_____

How many miles do you travel (round trip) for treatment?_____

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MEDICAL INFORMATION

NOTE: This section must be signed by a medical professional with knowledge of your diagnosis and treatment.

Date of diagnosis (day/month/year):_____

Type of cancer

- ☐ Colon
- ☐ Rectal
- ☐ Other (must specify) _____

Stage of cancer at time of diagnosis:_____

Is the patient currently undergoing chemotherapy or radiation treatment?

- ☐ Yes
- ☐ No (please specify patient's treatment plan):_____
  _____

I, _____ (please print clearly), am a healthcare provider (physician, nurse practitioner, nurse), and I attest that the patient's information listed above is accurate.

_____Date _____
Physician/Nurse Signature

Hospital/Clinic Name:_____

Hospital/Clinic Address:

_____
(Street Address)

_____
(City) (State) (Zip)

Hospital/Clinic Phone Number: (_____)_____

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HEALTH INSURANCE INFORMATION

Are you currently covered by private health insurance?

- ☐ Yes
- ☐ No

Does your health insurance cover prescription drugs?

- ☐ Yes
- ☐ No

Please list all other beneficial services which you are currently covered by including Medicare, Medicaid, VA Care (Tri Care), Charity Care.

_____

INCOME INFORMATION

Are you currently working?

- ☐ Yes
- ☐ No

Are you currently on medical leave?

- ☐ Yes
- ☐ No

Are you receiving disability?

- ☐ Yes
- ☐ No

Number of people in household (including yourself): _____

Number of people under the age of 18 in household:_____

What is your total yearly family income?_____

List all family sources of income (Examples: Social security, salary, pension, unemployment, public assistance, short-term disability, disability, help from family and friends):

_____

If you receive this grant, what do you intend to use the money for?

- ☐ Transportation
- ☐ Copays
- ☐ Hospital/doctor bills
- ☐ Household bills
- ☐ Other_____(please specify)

The Fighters' Fund provides assistance to patients and families who need it. Please provide an explanation of how The Fighters' Fund grant would give you hope in your current situation.

_____
_____
_____
_____

How did you hear about this grant?

_____

This application will not be considered if any information is missing or if false information is provided.

I, _____(please print name) understand that I may be asked to provide income verification to receive a grant from The Fighters' Fund. I also verify that all information provided is accurate to the best of my knowledge. I understand that this information will not be shared except with members of The Fighters' Fund Grant Approval Committee and Colon Cancer Prevention Project staff.

Applicant's Signature Date

Mail completed form to:

Colon Cancer Prevention Project
PO Box 4039
Louisville, KY 40204

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