Colon Cancer Prevention Project

The Fighters' Fund

We're in your corner.

About the Fighters' Fund

The Stanley R. Frager Fighters' Fund is a financial assistance program that provides one-time grants of $200 to qualifying patients based on need. Grants are awarded based on need and available funding. Grants are considered on a quarterly basis.

Applicants must meet all of the following qualifications:

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

Application Deadlines

For a grant to be considered during a particular quarter, applications must be faxed or mailed AND postmarked by that quarter's deadline (see list below).

1st quarter: Application Deadline: **April 1**
2nd quarter: Application Deadline: **July 1**
3rd quarter: Application Deadline: **Oct. 1**
4th quarter: Application Deadline: **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, completely fill out this form and mail to:
Colon Cancer Prevention Project
Attn: Fighters' Fund
PO Box 4039
Louisville, KY 40204

****Any unanswered questions or blanks will disqualify an application.****

Applications are also available at **kickingbutt.org.**

For more information, contact the Colon Cancer Prevention Project: **502-272-2397**

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's Fighters' Fund?

☐ Yes: You are **NOT** eligible to reapply; please go to kickingbutt.org for other resources.
☐ No

DEMOGRAPHIC INFORMATION

Name: _____
(First) (M.I.) (Last)

_____
(Street Address)

_____
(City) (State) (County) (Zip)

Phone Number: (_____)_____

E-mail: _____

Gender:

☐ Male
☐ Female

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

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

How often do you receive treatment or care? _____

OVER

Colon Cancer Prevention Project

HEALTH INSURANCE INFORMATION

Are you currently covered by health insurance?

□ Yes

Name of Insurance: _____

□ No

INCOME INFORMATION

Please fill out the following chart in its entirety. **All columns must be filled out for each member of the household. The contribution to household income is the gross yearly dollar amount of that individual's income**; if that individual has no income, simply put a zero.

First and Last Name	**Relationship to Head of Household**	**Date of Birth**	**Occupation** (Employed, At home, Handicapped, Student, etc.)	**Contribution to Household Income**
	Head			

****If additional space is needed, please attach a separate sheet to your application.****

If you receive this grant, what do you intend to use the money for? **Please rank the following categories in order of YOUR greatest financial need with "1" being the greatest need**. You may choose as many or as few as apply to you, but you must choose at least one category and label with a "1."

_____ Transportation

_____Medical expenses

_____Groceries

_____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
Attn: Fighters' Fund
PO Box 4039
Louisville, KY 40204

For more information, contact the Colon Cancer Prevention Project: (502) 290-0288 or (800) 841-6399.

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MEDICAL INFORMATION

****NOTE: This page must be completed IN ITS ENTIRETY by a medical professional with knowledge of your diagnosis and treatment.****

Provider Information:

Healthcare Provider Name: _____

Title: _____

Hospital/Clinic Name:_____

Hospital/Clinic Address:

_____

(Street Address)

_____

(City) (State) (Zip)

Hospital/Clinic Phone Number: (_____)_____

Patient Information:

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

Type of Cancer:

□ Colon Current Stage:_____

□ Rectal Current Stage:_____

Is the patient currently undergoing **(Check all that apply)**?

□ Chemotherapy

□ Radiation

□ Surgery (Date:_____)

□ Palliative Care

□ Hospice Care

□ Other (Please Specify): _____

□ No Current Care (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