Cancer Coalition Aid Fund Application

The Cancer Coalition sponsored by the Richland County Health Department (RCHD) has established the Cancer Coalition Aid Fund. The Cancer Coalition, with approval of the sponsoring RCHD & County Commissioners, has selected the Foundation for Community Care to act as a fiduciary institution serving at will to the RCHD Director, the Richland County Commissioners and the Cancer Coalition active membership.

The fund is designed to help individuals with an active cancer diagnosis, will be or are currently undergoing cancer treatment, and reside in Richland County. Patients in other Montana counties can be considered if seeking cancer treatment at the Sidney Health Center (SHC) Cancer Care located in Sidney, Montana. Funding can be granted one time per cancer diagnosis. The intent for this fund is to support cancer patients by offering financial assistance with *essential living expenses* (housing, food, utilities, medically necessary travel, etc.). Other avenues may be available for assistance with travel costs, hospital, physician and prescription charges if needed. Priority is given to those with financial need. Applicants will be notified of decision after committee review.

Application fulfillment will be subject to fund availability and will be processed within thirty (30) business days.

Patient diagnosed with cancer (Full Name) _____ **Age** _____

Treating Physician(s) _____

Type of Cancer _____

Person applying for funds (Full Name) _____

Relationship to diagnosed individual _____

Home Address _____
Street/Box City State Zip County

Home Phone _____ **Cell Phone** _____

Date of next appointment _____ at ☐ **SHC Cancer Care** ☐ **Other Location**: _____

Monthly household income $ _____ **# in household** _____ **Amount Requesting** $ _____

Signature of Applicant _____ Date _____

Please return this form to:

Foundation for Community Care
221 2nd Street Northwest
Sidney, Montana 59270
P: (406) 488-2273
F: (406) 488-2279

SIDNEY HEALTH CENTER CANCER CARE/PROVIDER USE ONLY

Patient listed on this application is verified as currently receiving care under the direction of SHC Cancer Care, has a valid care plan in place, and has a Release of Information signature on file.

Authorized Signature: _____ Date: _____

FOUNDATION FOR COMMUNITY CARE USE ONLY

Past Recipient: Y / N If YES, when: ____/____/____ New Diagnosis: Y / N

Eligible: Y / N Verified by: _____ Approved on ____/____/____

Amount $ _____ Check # _____ Awarded on ____/____/_____

Received by: _____

Approved Cancer Coalition 05.07.2013
Richland County attorney 05.29.2013
Updated Cancer Coalition 7.2.2015
Updated Cancer Coalition 12.30.2015
Updated Cancer Coalition 05.09.2019
Updated Cancer Coalition 08.08.2019
Updated Cancer Coalition 05/19/2020

Cancer Coalition Aid Fund
Consent to Inform

Informed Consent and Authorization to Disclose Health Care Information

The Cancer Coalition sponsored by the RCHD has established the Cancer Coalition Fund also known as the Cancer Coalition Aid Fund (CCF-CCAF). The fund is designed to help individuals with a cancer diagnosis and undergoing cancer treatment residing primarily in Richland County as well as Dawson, Fallon, McCone, Prairie and Wibaux Counties, residents of other Montana counties can be considered if seeking cancer treatment at the Cancer Center located in Sidney Montana. A Written Request Application and Release of Information form needs to be completed and forwarded to the Foundation for Community Care. Incomplete applications will not be accepted for approval by the committee.

A verified physician care plan is required for all applicants, additional information may be requested in order for the CCF-CCAF Committee to make its decision, including but not limited to a verification of active treatment from the attending physician. The fund supports cancer patients in offering assistance with non-medical household expenses. Excluded from assistance are hospital, physician and prescription charges, as other local avenues are available for these needs.

Any information provided by me and my doctor will remain confidential, which means that the information will be available only to me, my health care provider, and to the Foundation for Community Care Agent (FCCA) helping process the application. The FCCA means those personnel who are specifically designated to work on the Aid Fund Applications.

I consent to and authorize the mutual exchange of medical records among the FCCA, my health care provider(s), and myself. This authorization expires twelve months after the date in which I sign. I have read the information provided herein, discussed this, and other information about the Cancer Coalition Aid Fund and agree to informed consent. I have had an opportunity to ask questions about the Cancer Coalition and have received answers to any questions I had. All information I have provided to the FCCA is, to the best of my knowledge, true.

Attending Physician(s) Name & Phone Number: _____

Client Signature: _____ Date:_____

Print Full Name: _____