



# Greater Clermont Cancer Foundation

P O Box 443, Minneola, FL 34755-0443

www.gccf.us (352) 435-3202

## FORM 1 - Financial Grant Application

### Applicant Information

Your Name \_\_\_\_\_ US Citizen? YES \_\_\_ No \_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_  
 Contact Phones: Cell \_\_\_\_\_ Home \_\_\_\_\_ Other \_\_\_\_\_  
 Patient's Employer: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Patient's Spouse Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 Household Size: \_\_\_\_\_ Number of children & ages \_\_\_\_\_  
 Your Relation to Patient: Self \_\_\_ Spouse \_\_\_ Caregiver \_\_\_ Family Member \_\_\_ Other \_\_\_

### Patient Information

Cancer Patient's Name (if different from above) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Date of initial diagnosis? \_\_\_\_\_ Primary Cancer Type: \_\_\_\_\_  
 Stage of Cancer? \_\_\_\_\_ New Diagnosis? \_\_\_\_\_ Recurrence? \_\_\_\_\_  
 In Active Treatment? \_\_\_\_\_ If Yes, Indicate type of treatment (check all the apply):  
 Chemotherapy \_\_\_\_\_ Radiation \_\_\_\_\_ Clinical Trial \_\_\_\_\_ Hormonal \_\_\_\_\_  
 Surgery Type \_\_\_\_\_ Palliative/Alternative \_\_\_\_\_  
 Bone Marrow/Stem Cell Transplant \_\_\_\_\_ Date \_\_\_\_\_  
 If No, is post treatment follow up needed? Yes \_\_\_ No \_\_\_  
 If Yes, please indicate type of follow up:  
 Yearly \_\_\_\_\_ Every 6 months \_\_\_\_\_ Other \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Practice/Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address/City/State/Zip \_\_\_\_\_

### Patient's Medical Coverage Information

Does the patient have medical coverage? \_\_\_\_\_ If Yes, indicate the type (check all that apply)  
 If Yes, please indicate type (check all that apply)  
 Private Insurance? Name \_\_\_\_\_ Group? \_\_\_ Individual? \_\_\_  
 Medicare Only? \_\_\_ Medicare + other supplemental? \_\_\_ Name \_\_\_\_\_  
 Medicare & Medicaid? \_\_\_ Full Medicaid? \_\_\_ Share of Cost Medicaid? \_\_\_ \$ \_\_\_\_\_  
 Emergency Medicaid? \_\_\_ Medicaid pending? \_\_\_ Charity Care? \_\_\_  
 VA Program & Type \_\_\_\_\_ Are prescription drugs covered? Yes \_\_\_ No \_\_\_

Type Grant Requested: Patient Grant \_\_\_ Family/Caregiver Grant \_\_\_ Children's Grant \_\_\_

**Please attach a short written paragraph describing your request circumstances and how the potential grant would be utilized to aid the patient, the family/caregiver or the child of the cancer family.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MAIL COMPLETED APPLICATION TO GCCF, PO BOX 443, MINNEOLA, FL 34755-0443**

**A GCCF case manager will review your information and will contact the applicant requesting assistance. Funds are limited and based on availability.**

**All information is strictly confidential and is for GCCF use only.**