Greater Clermont Cancer Foundation

P O Box 443, Minneola, FL 34755-0443
www.gccf.us (352) 435-3202

FORM 3 - Day Wish 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 ______________________ Palitive/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 ______

Please attach a short written paragraph describing your request circumstances and how the potential Day Wish would be utilized by 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.