



Greater Clermont Cancer Foundation

P O Box 443, Minneola, FL 34755-0443 - Phone: (352) 435-3202

FORM 1 - Financial Grant Application - Page 1 of 2

Type of Patient Grant Requested: Adult _____ Child _____

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: _____

Employer Address: _____ Phone: _____

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): Radiation _____

Chemotherapy _____ Clinical Trial _____ Hormonal _____ Immunotherapy _____ Palliative _____ Hospice _____

Surgery Type _____ Alternative Type _____

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)

Private Insurance? Name _____ Group? _____ Individual? _____

Medicare Only? _____ Medicare + supplemental? _____ Medicare Advantage/Replacement Plan? _____

Medicare & Medicaid? _____ Full Medicaid? _____ Share of Cost Medicaid? _____ \$ _____

Emergency Medicaid? _____ Medicaid pending? _____ Charity Care? _____

VA Program & Type? _____ Have prescription drugs covered? Yes _____ No _____

Signature: _____ Date: _____

**Verification of any provided information may be requested.
A GCCF case manager will review your information and will
contact the applicant requesting assistance. Funds are limited and based on availability.
Processing of request can take up to 45 days.**

FORM 1 - Grant Application Questionnaire - Page 2 of 2

ALL QUESTIONS MUST BE ANSWERED

Have you or your family ever received assistance from GCCF before? Yes ___ No ___
If yes, who and when? _____

Have you or are you currently receiving assistance from any other organizations? Yes ___ No ___
If yes, list: _____

Do you have a local support system? Yes ___ No ___
If Yes, check all that apply: Family ___ Friends ___ Church ___ Other ___

Housing - Check all that apply:

Housing: Rent? ___ Live with others? ___ Own? ___ Do You have a mortgage? Yes ___ No ___
Your monthly cost for housing? _____ How long at current address? _____
Are you current on all your household bills? Yes ___ No ___

Employment & Income - Check all that apply:

Work Status: Full Time? ___ Part Time? ___ Retired? ___ Disabled? ___ Unemployed? ___
On leave of absence? Yes ___ No ___ Unpaid? ___ Paid? ___ Family Medical Leave? ___
Have you applied for disability? Yes ___ No ___ Denied? ___ If so, when? _____
Do you need more information on disability eligibility and application process? Yes ___ No ___

What is your total household monthly Income? _____

Income Sources: Number of working household members? ___ Relationship? _____
Social Security Retirement? ___ Social Security Disability? ___ SSI? ___ Pension? ___
Food Stamps? ___ Amount _____ Child Support? ___ Amount _____
Family Assistance? ___ Amount or bills they are paying _____

Medical Coverage - Check all that apply:

Have you applied for Medicaid? Yes ___ No ___ Denied? ___ If yes, when? _____
Do you need more information on Medicaid eligibility and application process? Yes ___ No ___

Do you have a co-payment at the Doctor's Office? YES ___ No ___ If yes, amount _____
How much is your annual insurance deductible? _____ Has it been met? Yes ___ No ___

Tell us a little about your current situation :

**MAIL COMPLETED APPLICATION TO:
GCCF, Post Office Box 443, Minneola, FL 34755-0443**