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 & birth years _____

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.

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 APPICATION TO:
GCCF, Post Office Box 443, Minneola, FL 34755-0443