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.

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 APPICATION TO:

GCCF, Post Office Box 443, Minneola, FL 34755-0443