

THE CHUCK SARRATT CANCER FOUNDATION, INC.

Providing HOPE to our community Helping Other People Endure

It is our mission to provide cancer support services, and financial assistance to families who endure economic hardships throughout their diagnosis and treatment of cancer.

FINANCIAL NEEDS APPLICATION

Date: _____

Applicant Information (*Applicant is the client who has the diagnosis of cancer.*)

First Name: _____ Last Name: _____

Address: _____

(Street Number and Street Name)

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Applicant's Date of Birth: - - Applicant's Social Security#
Month Day Year (last 4 digits only)

FAMILY INFORMATION

Single _____ Married _____ Divorce/Separated _____ Widow _____

Spouse's Name: _____

Spouse's Address and Phone Number(s) – if different than above:

Child(ren) – Name(s) and Age(s):

Client Name: _____

EMPLOYER INFORMATION

Applicant's Employer: _____

Company Address: _____

City: _____ State: _____ Zip: _____

Salary \$ _____ (Annually) or \$ _____ (hourly)

Spouse's Employer: _____

Company Address: _____

City: _____ State: _____ Zip: _____

Salary \$ _____ (Annually) or \$ _____ (hourly)

REQUESTING FINANCIAL ASSISTANCE

The Non-profit 501(c)(3) status of The Chuck Sarratt Cancer Foundation, Inc. (TCSCF) is governed by the United States IRS Dept., and is allowed only to act as a benevolent charity when issuing payment on behalf of its approved applicants. Any approved payments will be made directly to your financial institutions on your behalf (on or before the established date(s) approved by our review committee).

The normal TCSCF review committee process takes 30 days. Billing cycles and terms with your creditors will need to be considered when making application requests. TCSCF is never responsible for the payment of any client debt(s), and will be held harmless for such debts and it's payment(s). As a courtesy only, TCSCF will make every reasonable attempt to pay approved accounts in a timely manner that will benefit the client. Applicants will be notified of decisions, and benevolent payments will be outlined in writing for client records.

Application does not imply approval. All billing cycles, and payments remain the sole responsibility of the person(s) named on this application. Also, at times, due to limited or exhausted financial resources, TCSCF may be unable to approve grants, or respond to all applicants' requested items of need. In the event this occurs, our applicants will be notified in writing at the address submitted on this application. TCSCF will be held harmless for such event.

Financial Awards are temporary in nature, and should not be relied upon as an ongoing source of income. Our awards are designed to give a helping hand up and out of an immediate financial hardship. Proper financial planning is important, and we encourage our applicants to seek our (or other) resources that may serve in this area as well.

Client Name: _____

Requested Needs

For example: Rent/Mortgage, Grocery, Electric Bill, Water Bill, Phone Bill (no cell phone bills please), Support Group (Men, Women, Children, Caregiver), Prayer, etc...

ACCOUNT/CREDITOR INFORMATION:

CREDITOR NAME: _____

ACCOUNT #: _____

AMOUNT DUE: _____

DUE DATE: _____

PAYMENT ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

CREDITOR NAME: _____

ACCOUNT #: _____

AMOUNT DUE: _____

DUE DATE: _____

PAYMENT ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

ACCOUNT/CREDITOR INFORMATION:

CREDITOR NAME: _____

ACCOUNT #: _____

AMOUNT DUE: _____

DUE DATE: _____

PAYMENT ADDRESS: _____

CITY _____ **STATE** _____ **ZIP CODE** _____

(Add additional page if necessary)

Client Name _____

HEALTH INFORMATION

Diagnosis: _____

New or Recurring (N/R): _____

Physician Name: _____

Physician Address: _____

Physician Phone: _____

Hospital: _____

Treatment Plan (chemotherapy, radiation, surgery, other, etc. – please describe):

PROGNOSIS: _____

May we contact your physician for matters related specifically to our assistance to your family? Please circle: YES or NO

Have you filed for Social Security Disability Insurance: YES or NO (circle one)

If yes, please provide date of application (and copy of letter from physician stating disability). Date of Application: _____

Have you been accepted? YES or NO (circle one) If yes, when did you start receiving your checks? _____ Amount Received \$ _____

(Date)

Do you have a disability policy through your employer or a Private disability policy?

YES or NO (circle one) If yes, please provide date of when you applied, and when

benefits will begin (or have already begun): _____ Amount Received \$ _____

(Date)

Are you currently receiving or applied for other financial assistance? YES or NO (circle one)

If yes, please explain: (i.e. family, church, friends, Food Bank/Stamps, United Way, etc.)

Client Name _____

Sharing of your health information is necessary for The Chuck Sarratt Cancer Foundation, Inc.(TCSCF) to provide appropriate assessment of your request from the onset and throughout the duration of your diagnosis. NO PARTY affiliated with TCSCF will share, discuss, or disclose your personal financial or health related information to parties outside of the review board, unless there are affiliations we are working with on your behalf to secure the assistance you are requesting. Signing of this application; whether by the applicant, spouse of applicant, family representative, or legal power of attorney releases TCSCF., its board members, and respective volunteers from any liability and will hold harmless our non-profit organization for any wrong or willful doing specific to your care, or discussions surrounding the nature of your care.

The signing of this application grants The Chuck Sarratt Cancer Foundation, Inc. permission to speak with and share health information with your primary physician or any other specialty physician working on your specific treatment plan related to your cancer diagnosis, and acts as your agreement to all terms outlined in this application form. For additional information regarding HIPPA regulations, please contact our office at (888)861-5211 or visit www.hippa.org

NOTE

TCSCF is not a medical facility. We are not medically trained. We are a non-profit 501(c)(3) only qualified to provide this help by virtue of having walked this road with cancer ourselves. It is our desire to assist others by providing helpful resources, and benevolent giving as outlined in our mission statement and our Articles of Incorporation as filed with the State of Georgia.. The information garnered on your behalf will only be used for the explicit intent of providing the requested services. For additional information related to the complete purpose of our organization, please contact our office at (888)861-5211.

Applicant's Name (Please Print)

(Date)

Applicant's Signed name

(Date)

Spouse's Name or Other (Please Print)

(Date)

Spouse's Signature or Other

(Date)

***NOTE* PLEASE DO NOT WRITE BELOW THIS LINE – INTERNAL PROCESSING FOR CSCF BOARD MEMBERS**

No person(s) request will be discriminated against based on race, color, sex, religious beliefs, or national origin.

Date of Review: _____

Board Decision: _____

Contact Follow-up: _____

Phone Call(s): _____ **Letter(s)** _____

(dates/times)

(dates mailed)

**THE CHUCK SARRATT CANCER FOUNDATION, INC.
1504 CLEVELAND COURT
LOGANVILLE, GA 30052
(888) 861-5211**