Our mission is to reduce the stress of fighting cancer by assisting with the daily financial struggle that is experienced by cancer patients in our communities. We are literally *funding their fight*. If awarded, assistance is one grant of $1000.00, to be used for one of 5 specific needs described below. Please note that we cannot guarantee assistance to all applicants. Each month, based on fund availability, we must prioritize those in greatest need.

Do you meet Fund the Fight's eligibility criteria?

___**Yes** ___**No** I am 18 years or older, or I am applying for a patient 18 years or older.

___**Yes** ___**No** I am a Colorado resident

___**Yes** ___**No** I have a cancer diagnosis

___**Yes** ___**No** I am currently receiving chemotherapy, radiation or surgery, or I have completed these treatments within the last 60 days.

___**Yes** ___**No** I have a dire financial circumstance (my expenses are greater than my income).

___**Yes** ___**No** I agree that if awarded, I will share my story, through pictures and/or video, to help promote Fund the Fight in raising more money to help patients like me.

*If you answered **YES** to **every** question, you are eligible to apply for assistance from Fund the Fight (FTF).*

Income Guidelines

Household Size	***Gross Monthly Income***
1	***$35,640***
2	***$48,060***
3	***$60,480***
4	***$72,900***
5	***$85,320***
6	***$97,740***
7	***$110,190***
8	***$122,670***

Award Limits: Lifetime limit is two awards.

Allocation of Funds:

Allocation of funds will fund the following five patient expenses:

- Health Insurance Premium / Medical Bills
- Mortgage / Rent Payment
- Utilities

- Car Payment
- Travel expenses related to treatment

Each expense above are paid directly by Fund the Fight, and not by the awardee. All of the information required to make the transaction must be provided to Fund the Fight.

Applications are reviewed on a monthly basis. Referring professionals will be notified via email at the end of the month and the applicant will be notified via email.

Fund the Fight Contact Information

1001 16th Street, Suite 146

Denver, Colorado 80265

admin@fundthefight.com

PATIENT NAME: ____

MEDICAL VERIFICATION FORM - TO BE COMPLETED BY REFERRING PROFESSIONAL

Answer each question completely. Print clearly and use dark ink. Do not use abbreviations or codes for diagnosis and treatment.

Applicant name (if not patient):			
Cancer diagnosis:		Stage:	Date of diagnosis:
Describe current treatment:			Name of Physician:
Surgery (circle) YES NO	Date of Surgery:		
Chemotherapy (circle) YES NO	Begin Date:	Anticipated end date:	
Chemotherapy agent(s)			
Radiation	Begin Date:	Anticipated end date:	
Hormone	Begin Date:	Anticipated end date:	
Has the patient applied to Fund the Fight before?(circle) Yes No			
Is patient currently able to work? (circle) YES NO	If no, what date will patient return to work?		
Is patient disabled? (circle) YES NO	Date of disability?		

Patient Insurance status (circle): Private Insurance | Medicare | Medicaid | Uninsured | Underinsured

What is the patient's requested financial need (circle): Health Insurance Premium or Medical Bill | Mortgage / Rent Payment | Utilities | Car Payment | Travel expenses related to treatment

****For the application to be eligible, Fund the Fight must have the following contact information****

Name of referring professional (health care professional completing form):		
Facility Name:	Address:	
City:	State:	Zip:
Phone:	Email:	
Do you have any reservations concerning this patient's request for financial assistance? (circle) YES NO		
Referring professional's summary regarding patient and their household's financial situation. (**This is required, please include attachment as needed.)**		
Must be signed by referring professional (case worker, patient navigator, social worker, nurse, physician)		
My signature below affirms the diagnosis and treatment information as described on this page.		
Signature:	Date:	

PATIENT NAME: ____

PERSONAL DATA – TO BE COMPLETED BY GRANT APPLICANT

Applicant name (if not patient):			
Patient's Date of Birth:			Age:
Address:			Apt #:
City:	State		ZIP / County:
Phone	Home:	Work:	Cell:
Email Address:			
Additional contact person with whom we may discuss your application			
Name:	Phone:	Email:	
Patient Information:			
I am: (circle) **Single** | **Partnered** | **Domestic Partnership / Civil Union** | **Married** | **Separated** | **Divorced** | **Widowed**			
How, when and where is it easiest to reach you?			
Preferred Language:			
I am employed: (circle) **Full Time** | **Part Time** | **Self-Employed** | **Unemployed** | **Disabled** | **Retired** | **Veteran**			
If employed or disabled, who is/was your employer:			
How long have you worked for this employer?			
What kind of work do/did you do?			
After you have recovered, can you return to work for this employer? (circle) YES NO			
Is your spouse/partner employed? (circle) YES NO	Type of work?		
What is the name of your spouse/partner's employer?			

List the name of all people living in your home

Name	Relationship	Age	Employment (of adults over 18)				
			Full Time	Part Time	Disabled	Retired	Unemployed

Comments (Explain unmployed or other situation)

Signature: Date:

PATIENT NAME: ____

INCOME & ASSETS – TO BE COMPLETED BY GRANT APPLICANT

Tell us about your current total household income. Please report gross earnings (before taxes or other deductions). Attach copies of income documentation for your entire household (paystubs, social security, pension statements, etc).			
Income	**Gross Monthly Amount ($)**	**Start Date** (date you began receiving income)	**End Date** (date you stopped receiving income)
1. Your gross monthly income from working			
2. Your spouse/partner's gross monthly income from working			
3. Other household members' gross monthly income			
4. Monthly disability payments:			
a. Sick leave pay			
b. Employer group disability insurance			
c. Workers' compensation			
d. Any personal disability insurance			
e. VA benefits			
f. SSI or SSDI (circle one)			
5. Social security retirement benefits			
6. Retirement, pension, 401-K or IRA			
7. Child support			
8. Spousal support			
9. Public Assistance			
10. Food Stamps			
11. Other income (unemployment or other ongoing income) Describe:			
12. Family and friends' contributions			
Total Gross Monthly Income			
ASSETS	Current Value $	Current Loan $	
1. Do you own or are you buying a home? YES NO			
2. Do you own or are you buying a car? YES NO			
3. Do you own or are you buying another car? YES NO			
4. Checking account balance: $	Bank Name:		
5. Savings account balance: $	Bank Name:		
Circle appropriate answer. If yes, provide value, loan, and income.	**Value $**	**Loan $**	**Income $**
6. Do you own a business or any part of a business?* YES NO			
7. Do you have any investments, stocks or bonds?* YES NO			
8. Do you have any rental properties?* YES NO			
9. Do you own any other real estate properties?* YES NO			
10. Do you own any annuities?* YES NO			
11. Do you own "cash value" life insurance?* YES NO			
12. Do you have any other assets?* YES NO			
***Note:** **If you answer "yes" to question #6, please provide a current balance sheet for your business. If you answer "yes" to questions 6-12 please provide your most recent income tax return.**			
Signature:	Date:		

PATIENT NAME: ____

EXPENSES – TO BE COMPLETED BY GRANT APPLICANT

Prioritize your expenses in the "Priority of Need" highlighted column with #1 being the most important expense. Please list **all** of your household expenses so that we have an accurate picture of your financial situation. **Providing complete and accurate information will help us to help you.**

Monthly Expenses				
Expense	Monthly Payment/Amount $	How Often	Total Balance	Priority of Need
1. Rent or Mortgage (plus HOA) **Payment is made to:**				
2. Health Insurance Premium				
3. Other Medical Bills (Prescription/Medical after insurance)				
4. Utilities (electric, gas, water, trash, cell phone service)				
5. Car Payment				
6. Travel Expenses Related to Cancer Treatment				
7. All other travel expenses (bus pass, cab, other)				
8. Child care/Child support				
9. Monthly food expense*: **$175/mo X # in house =**				
10. Pet Care				
11. Tuition				
12. TV / Internet				
13. Gasoline / Oil				
14. Car Insurance				
15. Life insurance (for you)				
16. Life insurance for your family				
17. Other non-medical bills or payments*				
18. Loan repayments				
19. Credit Card Payments				
Total Monthly Payments				

*Please describe other expenses here:

Signature: Date:

PATIENT NAME: ____

Grant Request Application – TO BE COMPLETED BY GRANT APPLICANT

Have you applied to other agencies for assistance (circle) YES NO
If yes, please list the agency and their response to your request for assistance. If no, why not? **(We strongly encourage you to seek assistance from any and all agencies and resources. Assistance from other resources does not affect eligibility with Fund the Fight.**
Summarize your current financial situation **(This is required).** Include an attachment as needed.
I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Fund the Fight to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my case that might be helpful in assessing my application. I release Fund the fight of all liabilities or claims arising out of the donation of money or services provided to me or my family.
Applicant's Signature: Date:

- ○ **By checking this circle, I allow Fund the Fight to use my story to solicit donations/funding to further help others undergoing cancer treatment in Funding their Fight.**

APPLICATION CHECK LIST

- ○ **My name is on every page of this application.**
- ○ **I have verified that my income does not exceed the guidelines listed on the application cover page.**
- ○ **I have included all income and expense information for my entire household.**
- ○ **I have totaled the amounts on the income and expense pages.** (pages 3 and 4)
- ○ **I have attached copies of household income documentation** (recent paystubs, social security statements, pension statements, etc.)
- ○ **I have attached copies of the bills I would like to be considered for assistance that fit one of the five options Fund the Fight will consider. The copy includes the name on the account, the account number** (if applicable) **and the amount due.** (Do not include bills for medical expenses, life insurance, credit cards, or bills payable to family members.)
- ○ **I have attached a copy of my photo I.D.**
- ○ **If applicable, I have included my most recent income tax return or balance sheet for my business** (see the "Assets" section on Page 3).
- ○ **A health care professional that is knowledgeable about my diagnosis and treatment has completed and signed page 1 of the application.**
- ○ **I have signed this application.**