HATTERAS ISLAND CANCER FOUNDATION, INC.

PO BOX 442

HATTERAS, NC 27943

APPLICATION FOR GRANT FOR INDIVIDUALS OR FAMILIES

Hatteras Island Cancer Foundation will award grants to individuals diagnosed with cancer in order to help them defray the costs of treatment. ***An applicant must be a full time resident of Hatteras Island, and provide a copy of a photo ID with a Hatteras Island address along with this application.*** The foundation may assist you with the cost of travel, food, lodging and parking while seeking treatment off the island as well as medical and pharmacy bills not covered or not completely covered by insurance. If your grant application is approved, this does not guarantee full payment of all submitted bills.

If you request assistance with medical bills, you must provide a copy of the bills that have already been processed through your insurance company, if applicable. Please keep a copy for your records. In order to reimburse for mileage a travel form must be completed and initialed or stamped by the doctor's office you are visiting. Forms may be downloaded from our website at www.HICF.org.

Grant applications are reviewed the 3rd week of every month. Information provided in the application will be kept in the strictest of confidence.

The person signing this application warrants the information provided is true. Hatteras Island Cancer Foundation is authorized to make all inquiries deemed necessary to verify the accuracy of the statements herein.

_____ Date:_____

Signature of Applicant

APPLICANT INFORMATION

Name: _____ Age:_____

Physical Address: _____

Mailing Address: _____

Email Address: _____

Phone: _____ Alternative Phone:_____

Are you a full time resident of Hatteras Island? Yes____ No _____

Employer of Applicant: _____

Address of Employer: _____

Other members of household (those living with applicants)

Full Name	**Relationship**	**Age**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Type of Cancer: _____

Date of Diagnosis: _____

Primary Care Physician: _____

Do you have Medical Insurance: Yes or No

If yes, Name of Primary insurance Company: _____

Name of Secondary insurance Company: _____

Do you have a supplemental cancer insurance? If so, name of insurance company:

_____

What type of assistance do you expect you will need? (Medical bills, pharmacy bills, travel expenses, etc.) Please list in order of importance according to your financial needs.

1_____

2._____

3._____

4._____

Have you or anyone in this family applied for a grant from the Hatteras Island Cancer Foundation?

Yes____ No_____ If yes, Date: _____ Name of person in household: _____

HOUSEHOLD INCOME

Applicant wages – monthly **_____**

Spouse or other wages – monthly **_____**

Child support – monthly **_____**

Unemployment – monthly **_____**

Other Income– monthly **_____**

Total Household Income **_____**

HOUSEHOLD EXPENSES

Rent/Mortgage **_____**

Utilities – monthly **_____**

Child Care – monthly **_____**

Medical – monthly **_____**

Insurance – monthly **_____**

Other – monthly **_____**

Total Household Expenses **_____**

DO YOU HAVE ADDITIONAL FUNDS THAT CAN BE DRAWN FROM (such as checking, savings, stocks, bonds, retirement funds, etc)?

Yes _____ No _____

If Yes, please list the value of the assets

$10,000 - $25,000 **_____**

$25,000 - $100,000 **_____**

Over $100,000 **_____**

DO YOU CONSENT TO ALLOW HICF TO CONTACT YOUR MEDICAL PROVIDERS IN ATTEMPS TO NEGOTIATE AND LOWER YOUR BILLS?

Yes _____ No _____