

**HATTERAS ISLAND CANCER FOUNDATION, INC.**

**PO BOX 442**

**HATTERAS, NC 27943**

**GRANT APPLICATION 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](http://www.HICF.org).

Grant applications are reviewed the 3<sup>rd</sup> week of every month. Information provided in the application will be kept in the strictest 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:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**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 ATTEMPTS TO NEGOTIATE AND LOWER YOUR BILLS?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**DO YOU GIVE CONSENT TO SOMEONE OTHER THAN YOURSELF TO DISCUSS YOUR MEDICAL AND/OR FINANCIAL INFORMATION?**

Yes \_\_\_\_\_ No \_\_\_\_\_

**IF YES, GIVE NAME OF INDIVIDUAL AND CONTACT INFORMATION:**

**NAME:** \_\_\_\_\_ **PHONE NUMBER:** \_\_\_\_\_

**I HEREBY GIVE THE ABOVE INDIVIDUAL CONSENT TO DISCUSS MY MEDICAL AND/OR FINANCIAL INFORMATION.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_