**This application is for both organizations. Please send a copy to each individual organization to which you are applying. Eligibility varies between organizations, so carefully confirm your eligibility using the checklists below.**

**Complete application includes:**

- Five pages of the application.
- Treatment dates (beginning and ending) and type of treatment.
- Copy of most recent pay stub(s) and/or award letter(s) for **all** household income.
- Copies of the most recent statements for the top two priority non-medical expenses (e.g. mortgage, utility, etc.) as identified on page 4 in the "Priority of Need" column.
- Copy of the applicant's photo identification.
- Applicant's signature on page 5.
- **Note:** ***Incomplete applications will not be reviewed until requested info is received.***

RMCA

ROCKY MOUNTAIN CANCER ASSISTANCE

RMCA is a Colorado-based nonprofit organization that provides financial assistance for the basic living needs of cancer patients receiving treatment in Colorado. Assistance is for rent or mortgage, utilities (heat, lights, water), telephone, car payments, health insurance or COBRA, and other basic expenses.

**Do you meet RMCA's eligibility criteria?**

__Yes __NoI am 18 years or older.

__Yes __NoI have a cancer diagnosis.

__Yes __NoI am currently receiving cancer-fighting treatment in Colorado (including surgery, chemotherapy, radiation, and hormone treatments) or I have completed one of these treatments within the past month.

__Yes __NoThe **gross** income for everyone in my home does not exceed the income guideline below.

__Yes __NoI have a dire financial circumstance.

*If you answered **YES** to **every** question, you are eligible to apply for assistance from RMCA.*

**Income Guidelines**

| # in Household | Gross Monthly Income |
|---|---|
| 1 | $1,588 |
| 2 | $2,145 |
| 3 | $2,702 |
| 4 | $3,259 |
| 5 | $3,817 |
| 6 | $4,374 |
| 7 | $4,931 |
| 8 | $5,488 |
| *Add $557 for each additional person* | |

- 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 by mail.

**RMCA Contact Information**
P.O. Box 6625, Denver, CO 80206
**fax**: 888-600-4452
**phone**: 720-229-0303
rmca@rockymountaincancerassistance.org

RAY OF HOPE
CANCER FOUNDATION
Assisting Coloradans in Cancer Treatment

Our mission is to generate hope by lessening the daily financial struggles experienced by cancer patients in our community. If awarded, assistance is one grant of $500 ($1,000 for pediatric) directly to the applicant. Please note that we cannot guarantee assistance to all applicants. Each month we must prioritize those in greatest need.

**Do you meet Ray of Hope's eligibility criteria?**

__Yes __No I am 18 years or older, or I am the parent/guardian of a patient under 18

__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 one of these treatments within the past month.

__Yes __No I have a dire financial circumstance (my expenses are greater than my income.)

*If you answered **YES** to **every** question, you are eligible to apply for assistance from RWF.*

***Award Limits:***Applicants may receive only one award within a 12-month period. Lifetime limit is two awards.

**Applications are due the last day of each month.** The Grants Committee reviews applications the 2nd Monday of each month, and checks are mailed by the 3rd Monday of the month. Referring professionals will be notified by email, and the applicant is notified by mail.

**Submit your application by fax or mail to:**
Ray of Hope Cancer Foundation
3455 Ringsby Court #111
Denver, CO 80216
Fax: 303.499.9229

**Questions:**
Phone: 720.300.2095
Email: grants@rayofhopecolorado.org

**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.**

| | |
|---|---|
| Parent/Guardian name (if patient is under 18): | |
| Cancer diagnosis: Stage: | Date of diagnosis: |
| Describe current treatment: | Name of physician: |
| Surgery ☐ Date of Surgery: | |
| Chemotherapy ☐ 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 RMCA or Ray of Hope (formerly The Raymond Wentz Foundation) before? YES NO | |
| If yes, which organization and when? | |
| Is patient currently able to work? YES NO | If no, what date will patient return to work? |
| Is patient disabled? YES NO | Date of disability: |
| Patient insurance status: Private insurance ☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Underinsured ☐ | |
| What are patient's financial needs: ☐ Utilities ☐ Medical ☐ Rent ☐ Mortgage ☐ Food ☐ Transportation ☐ Financial Assistance | |
| ****For the application to be eligible, we must have the following contact information**** | |
| Name of referring professional (*health care professional completing form*): | |
| Facility Name: Address: | |
| City: State: ZIP: | |
| Phone: ( ) E-mail: | |
| Do you have any reservations concerning this patient's request for financial assistance? YES NO | |
| Referring professional's summary regarding patient and their household's financial situation: **(This is required, please include as attachment as needed)** | |
| | |
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| | |
| **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: |

**PERSONAL DATA**—TO BE COMPLETED BY GRANT APPLICANT *(or parent/guardian if patient is under 18)*
**Answer each question completely. Print clearly and use dark ink.**

| | | | | |
|---|---|---|---|---|
| Parent/Guardian name (if patient is under 18): | | | | |
| Patient's Date of Birth: | | | | Age: |
| Address: | | | | Apt #: |
| City: | | State: | ZIP: | County: |
| Phone | Home ( ) | Work ( ) | | Cell ( ) |
| E-mail address: | | | | |
| Additional contact person with whom we may discuss your application: | | | | |
| Name/Contact information: | | | | |
| I am: ☐Single ☐Partnered ☐Domestic Partnership/Civil Union ☐Married ☐Separated ☐Divorced☐Widowed | | | | |
| Gender identification: ☐Female ☐Male ☐Transgender ☐Gender non-conforming ☐Other | | | | |
| *These questions are optional and your answers are confidential. This information is only reported generally and anonymously, to help policymakers and advocates better understand and address health disparities in underserved groups.*<br>Sexual Orientation: ☐Heterosexual ☐Gay/Lesbian ☐Bisexual ☐Other<br>Ethnicity:☐African-American or Black☐Asian or Pacific Islander☐White – Non-Hispanic ☐Hispanic ☐Native American ☐Other: | | | | |
| How, when,and where is it easiest to reach you? | | | | |
| Preferred language: | | | | |
| I am employed:☐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? YES NO | | | | |
| Is your spouse/partner employed? YES NO | Type of work? | | | |
| What is the name of your spouse/partner's employer? | | | | |

**List the names of all people living in your home**

| Name | Relationship | Age | Employment (of adults over 18) | | | | |
|---|---|---|---|---|---|---|---|
| | | | Full time | Part time | Disabled | Retired | Unemployed |
| | | | | | | | |
| | | | | | | | |
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Comments(Explain unemployed or other situation)

## **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 this income)* | **End Date** *(date you stopped receiving this 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 | $ | | |
| **TotalGross 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.**

**EXPENSES**— TO BE COMPLETED BY GRANT APPLICANT

**Prioritize your expenses in the "Priority of Need" column with #1 being the most important expense.**

Please list**all** of your household's expenses on this page 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** |
| Rent or mortgage<br>→**Payment is made to:** _____ | $ | | | |
| 2) HOA fees | $ | | | |
| 3) Utilities (electric, gas, water, trash service) | $ | | | |
| 4) Monthly food expense*: **$200/m x # in house =** | $ | | | |
| 5) Child care/child support | $ | | | |
| 6) Pet care | $ | | | |
| 7) Tuition | $ | | | |
| 8) Telephone (land/cell), TV, Internet | $ | | | |
| 9) Your car payment | $ | | | |
| 10) Your household members' car payment (s) | $ | | | |
| 11) Transportation *(bus pass, cab, or other expense)* | $ | | | |
| 12) Gasoline and oil | $ | | | |
| 13) Insurance: | | | | |
| a) Health | $ | | | |
| b) Car | $ | | | |
| c) Home/renters*(if not included w/mortgage)* | $ | | | |
| d) Life insurance for you | $ | | | |
| e) Life insurance for your family | $ | | | |
| 14) Other Non-Medical bills or payments* | $ | | | |
| 15) Property taxes*(if not included w/mortgage)* | $ | | | |
| 16) Loan repayments | $ | | | |
| 17) Credit card payments | $ | | | |
| 18) Taxes and other payroll deductions* | $ | | | |
| 19) Prescription costs after insurance | $ | | | |
| 20) Other medical costs after insurance* | $ | | | |
| **Total Monthly Expenses** | $ | | | |

*Please describe otherexpenses here:

**GRANT REQUEST APPLICATION**—TO BE COMPLETED BY GRANT APPLICANT

| |
|---|
| Have you applied to other agencies for assistance? YES NO<br>If yes, please list the agency and their response to your request for assistance. If no, why not?<br>***(We strongly encourage you to seek assistance from any and all agencies and resources. Assistance from other resources does not affect eligibility with RMCA or Ray of Hope.)*** |
| |
| |
| |
| |
| Summarizeyour current financial situation**(This is required).** Include as attachment as needed. |
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| |
| *I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Rocky Mountain Cancer Assistance andRay of Hope Cancer Foundationto obtain from the individuals, businesses, organizations, agencies, or entities listed in this applicationwhatever information is necessary about my case that might be helpful for assessing my application. I release Rocky Mountain Cancer Assistance andRay of Hope Cancer Foundation 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 box, I allow Rocky Mountain Cancer Assistance and/or Ray of Hope Cancer Foundationto use my story (minus identifying characteristics) to solicit donations/funding to further help others undergoing cancer treatment.**

## 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, if I am applying to RMCA**.(This does not apply to Ray of Hope Cancer Foundation)
- ☐ **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 that I would like to be considered for assistance. 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 healthcare professional that is knowledgeable about my diagnosis and treatment has completed and signed page 1 of the application.**
- ☐ **I have signed this application.**