A 501-(c)(3) NON-PROFIT ORGANIZATION

SMALL GIFT PROGRAM

Form Updated 4/23/19

REQUEST FOR IMMEDIATE/EMERGENCY ASSISTANCE

COMMUNITY RESOURCE PARTNER
i.e. Navigator. Social. Worker. Doctor

NAME: _____

JOBTITLE: _____

COMPANY: _____

ADDRESS: _____

CITY/ST/ZIP: _____

PHONE: _____

EMAIL: _____

RECIPIENT INFORMATION

PATIENTS NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

COUNTY: _____ **PHONE:** _____

DIAGNOSIS: _____

DOB: _____ **GENDER:** _____

EMAIL: _____

REQUIREMENTS:

- You must be a resident of South Carolina living in or being treated in one of the following counties of Calhoun, Chester, Fairfield, Kershaw, Lee, Lexington, Newberry, Orangeburg, Richland, Saluda and Sumter.
- You must provide a statement from your physician on their letterhead stating that you are currently under active therapy/treatment. (Maintenance care will not be applicable for this benefit. Maintenance care is considered routine physician visits, labs, scans, drugs, etc.)
- A Community Resource Partner (CRP), such as, social worker, nurse navigator or doctor must sign application certifying that you need assistance.
- Along with the application, you must provide copies of the current bill/s that you are requesting help with. Eviction notices and Independent Landlords must submit additional information. Please notify CMC requesting those forms.
- All gifts are paid directly to the vendor. *CMC only assist with non-medical bills. There are no age restrictions for the recipients of the gift.

TREATMENT FACILITY: _____

NAME OF PHYSICIAN: _____

Please ***describe in detail*** the patient's circumstances / reason for the specific needs of assistance.

(You may attach another sheet of paper if necessary):

SERVICES WHERE ASSISTANCE IS NEEDED

State ***exactly*** what services are needed. Please provide ***qualified*** documentation from the vendor/company for which the patient needs assistance. ***(Qualified documentation*** *is a current invoice from business on company's letterhead.)* If request is approved, the funds will be payable directly to the vendor with a maximum gift of up to $500. Have you ever applied for assistance from CMC? YES_____ NO _____

VENDOR / COMPANY		BEHIND	AMOUNT
1. Name:	_____	# Month's _____	$ _____
2. Name:	_____	# Month's _____	$ _____
3. Name:	_____	# Month's _____	$ _____
4. Name:	_____	# Month's _____	$ _____
5. Name:	_____	# Month's _____	$ _____

ANTICIPATED COST OF GIFT **$** _____

I _____, certify that the above-named patient needs immediate assistance with their basic living expenses. The patient and family are having a difficult time receiving help from their immediate family, friends and other programs. I certify all the information is true and complete to my knowledge. Cancer of Many Colors supports those burdened by a cancer diagnosis by providing temporary financial support to those needing help with their basic living expenses***. (NOTE: Cancer of Many Colors, Inc. does not provide continuing funding. However, exceptions can be reviewed, on a case by case basis, for an individual financial need of a basic living expense. Gift exceptions may only be granted by the Board of Director's approval.)***

COMMUNITY RESOURCE PARTNER: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____

By signing the Small Gift Application, I'm giving CMC permission to discuss any billing information with the attached businesses to expedite my request for assistance. I'm also giving CMC permission to post pictures of me and a testimonial on the CMC website.* ****Electronic signature will be accepted as signed application.*

Email documents to: info@cancerofmanycolors.com (Include application, physician statement & copy of expenses for faster turnaround time. Sent via US Post Office takes longer.)