SMALL GIFT PROGRAM

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

REQUEST FOR IMMEDIATE/EMERGENCY ASSISTANCE

COMMUNITY RESOURCE PARTNER

NAME: _____

JOB TITLE: _____

COMPANY: _____

ADDRESS: _____

CITY/ST/ZIP: _____

PHONE: _____

EMAIL: _____

RECIPIENT INFORMATION

PATIENTS NAME: _____

ADDRESS: _____

CITY/ST/ZIP: _____

COUNTY: _____ **PHONE:** _____

DIAGNOSIS: _____

DOB: _____ **GENDER:** _____

EMAIL: _____

Requirements: You have to be a resident of South Carolina living in the counties of Calhoun, Chester, Fairfield, Kershaw, Lee, Lexington, Newberry, Orangeburg, Richland, Saluda and Sumter. You will need a statement from your physician on their letterhead stating that you are currently under his/her care. You will need a patient advocate, social worker or community resource partner to sign the application certifying that you need assistance and you will need copies of the current bills that you are requesting help with. All gifts are paid directly to the vendor. CMC Small Gift Program helps to support transportation costs, mortgage/rent payments, food, utility bills, out-of-state lodging, other unforeseen or unexpected expenses, and emergency needs. CMC only assist with non-medical bills. There are no age restrictions for the recipients of the gift.

TREATMENT FACILITY: _____

NAME OF PHYSICIAN: _____

(Provide statement from your physician that you are currently under his/her care. Statement must be on the physician/provider's letterhead.)

Please ***describe in detail*** the patient's circumstances / reason for the specific needs of assistance. *(You may attach another sheet of paper if necessary):*

Mailing Address: 100 Old Cherokee Road, Suite F - #339, Lexington SC 29072 / 803.957.1048
Website: www.cancerofmanycolors.com / Email: info@cancerofmanycolors.com

CANCER of many colors

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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 annual gift of up to $500. Can reapply after one year. Have you ever applied for assistance? 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.)***

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.)

OFFICE USE ONLY ☐ ***APPROVED*** ☐ ***DENIED***

Assessment Committee Chair: _____ **Date:** _____ **$ Amount:** _____

Board of Directors Chair: _____ **Date:** _____

COMMENTS: _____

_____

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