JAMES L. QUINT FOUNDATION
1519 East 133rd Avenue
Thornton, Colorado 80241
303-428-5983
www.jameslquintfoundation.org

How We Can Help

The James L. Quint Foundation helps with cancer treatment which includes prescriptions, nutritional supplies, medical supplies, transportation to treatment facilities or physician facilities, insurance premium payments and COBRA payments.

Guidelines of Grants:

Grant applicants must have a cancer diagnosis and be receiving active cancer treatment or palliative treatment.

Grant applicants must reside in Colorado.

The James L. Quint Foundation is not able to fulfill every request. While we make every attempt possible to grant assistance, some requests may be denied and some approved at an amount that is less than requested. We will inform you of our decision. The Board of Directors meets the first Monday of every month.

Please enclose the following:

Copy of identification in the form of passport, driver's license or State of Colorado issued identification. The completed **original** application with any bills that applicant wishes to be considered for payment. Copies of bills and Colorado Identification are accepted. We cannot accept faxes or copies of signatures for the applicant or medical verification.

Please submit original documents to:

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APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Personal Information - *To be completed by applicant requesting assistance*

First Name_____ Middle Initial_____ Last Name _____

Address_____ City, State, Zip_____

Phone Number Home_____ Work_____

Cell_____ Email Address_____

Date of Birth_____ If patient is a minor, name of parent or guardian_____

Male_____ Female_____ Marital Status Single___ Married___ Widowed____ Divorced____ Separated____

Health Insurance Information

Does patient have health insurance? Yes___ No___

Insurance, please indicate type of insurance:

Private Insurance____ Medicare____ Medicaid____ Charity____ VA____ Uninsured____ Underinsured____

Other (explain)_____

Are prescription drugs covered? Yes___ No___

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Patient Name_____

Household Financial Information – *To be completed by applicant requesting assistance*

Is patient currently employed? Yes____ No____

Number of people in household_____

Family income

Social Security_____ Pension_____ Unemployment_____ SSI_____ Public Assistance_____

Salary_____ SSD (Disability)_____ Other – explain_____

Total Annual Family Income_____

Financial Assistance – *To be completed by applicant requesting assistance*

I am requesting help with the following:

Transportation_____ Home care_____ Medical_____ Pain Medication_____ COBRA _____

Other (please explain) _____

I certify that the information provided on this application is true and correct to the best of my knowledge. I release James L. Quint 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_____

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MEDICAL VERIFICATION

MUST BE COMPLETED BY REFERRING PROFESSIONAL (case worker, social worker, patient navigator, registered nurse, physician)

Patient Name_____

Date of diagnosis_____

Type of Cancer_____Stage_____

Type of current treatment (please list dates of first/last treatment) _____

_____

Is patient in active treatment? Yes __ No __

Please indicate type of treatment received in past twelve months:

Chemotherapy ___ Radiation ____ Surgery ____ Palliative care ___ Other_____

Name of physician _____

Address_____ City, State, Zip _____

Phone_____ Fax _____

Please include any information concerning patient's financial status_____

_____

Name and Address of Referring Professional_____

Name and Address of Facility _____

City, State, Zip_____ Phone_____

Signature of Referring Professional_____ Date_____