This application is for each of these three 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.
- 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 __No I am 18 years or older.

__Yes __No I have a cancer diagnosis.

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

__Yes __No I 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	$1,732
2	$2,336
3	$2,940
4	$3,544
5	$4,148
6	$4,752
7	$5,356
8	$5,960

Add $604 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
Phone: 720.229.0303 Fax: 888.600.4452
rmca@rockymountaincancerassistance.org

Sense of Security

Sense of Security provides relief from financial hardship and enhances the quality of life for breast cancer patients in treatment. We provide assistance for housing, food, utilities, transportation, insurance, and other basic household expenses.

Do you meet our eligibility criteria?

__Yes __No I am 18 years or older

__Yes __No I am a Colorado resident

__Yes __No I have **BREAST CANCER**

__Yes __No I am currently receiving cancer-treatment in Colorado (surgery, chemotherapy, or radiation)

__Yes __No The **gross** income for everyone in my home does not exceed the income guideline below

__Yes __No I have a dire financial circumstance

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

Income Guidelines

# in Household	Gross Monthly Income
1	$2,452
2	$3,319
3	$4,185
4	$5,052
5	$5,919
6	$6,785
7	$7,652
8	$8,419

Add $347 for each additional person

- Applications are reviewed as received.
- Referring professionals will be notified via email at the end of the month and the applicant will be notified by mail
- A wait list exceeding six months exists.

Sense of Security Contact Information:
1355 S. Colorado Blvd., Suite AC302
Denver, CO 80222
Phone: 303.669.3113 Fax: 303.635.3113
grants@senseofsecurity.org

Ray of Hope

RAY OF HOPE
CANCER FOUNDATION

Ray of Hope's 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 our 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 ROH..*

Applications are due the last day of the 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.

Ray of Hope Contact Information:
3455 Ringsby Court #111
Denver, CO 80216
Phone: 720.300.2095
Fax: 303.499.9229
grants@rayofhopecolorado.org

Award limit: RMCA and Ray of Hope grant applicants may receive one award per twelve-month period, and a maximum of two lifetime awards. Sense of Security grant recipients may receive one six-month maximum grant in a lifetime.

MEDICAL VERIFICATION FORM — TO BE COMPLETED BY REFERRING PROFESSIONAL

Do not use abbreviations or codes for diagnosis and treatment. Do not send medical records.
Answer each question completely. Print clearly and use dark ink.

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:	
Patient insurance status: None ☐ Medicare ☐ Medicaid ☐ CICP ☐ VA ☐ Private ☐ Other: _____	
Has the patient applied to RMCA, Ray of Hope or Sense of Security 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:
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)**	
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:
Mailing Address:				Apt #:
City:		State:	ZIP:	County:
Phone	Home ( )	Work ( )		Cell ( )
E-mail address:				
Name of additional contact person with whom we may discuss your application:				
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.

Sexual Orientation: ☐Heterosexual ☐Gay/Lesbian ☐Bisexual ☐Other
Ethnicity: ☐African-American or Black ☐Asian or Pacific Islander ☐White – Non-Hispanic ☐Hispanic ☐Native American ☐Other:
Education: ☐Grade School ☐High School ☐College ☐Post-Graduate

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 N/A	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
This applicant	**self**						

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 letters, 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	$		
Total Gross 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.**

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**	**Total Balance**	**Priority of Need**
Rent or mortgage →**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 other expenses here:

GRANT REQUEST APPLICATION —TO BE COMPLETED BY GRANT APPLICANT

Have you applied to other agencies for assistance? YES NO If yes, please list the agency and their response to your request for assistance. If no, why not? ***(We strongly encourage you to seek assistance from any and all agencies and resources. Assistance from other resources does not affect eligibility.)***
Summarize your current financial situation **(This is required).** Include as attachment as needed.
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, Ray of Hope Cancer Foundation and Sense of Security to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my case that might be helpful for assessing my application. *I release Rocky Mountain Cancer Assistance, Ray of Hope Cancer Foundation and Sense of Security 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, Ray of Hope and/or Sense of Security to 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 or SOS**.(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 letters, pension statements, etc.)
- ☐ **I have attached copies of the most recent statements for my top two (2) priority non-medical expenses (e.g. mortgage, utility, etc.) as identified on page 4 in the "Priority of Need" column. 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.**
- ☐ **A health care professional that is knowledgeable about my diagnosis and treatment has completed and signed page 1 of the application.**
- ☐ **I have signed this application.**

Additional Resources for 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 household expenses.

www.rockymountaincancerassistance.org **720-229-0303**

You or a loved one may qualify for a Ray of Hope grant if cancer treatment is impeding on your ability to meet your basic needs.

www.rayofhopecolorado.org **720-300-2095**

Providing relief from financial hardship and enhancing the quality of life for breast cancer patients in treatment. We provide assistance for rent/mortgage, food, utilities, telephone, car payments, childcare, health insurance or COBRA, and other basic household expenses. www.senseofsecurity.org **303-669-3113**

Delivering nutritious meals to improve quality of life, at no cost, for those coping with life-threatening illness in the Denver Metro area and Colorado Springs. Qualified breast cancer patients will be prioritized for service, thanks to support from Komen Colorado.

www.ProjectAngelHeart.org **303-830-0202**

Free counseling and support groups (phone or online). Financial and co-payment assistance. Education.

www.cancercare.org **800-813-HOPE (4673)**

Help understanding your cancer diagnosis and treatment process, providing information and identifying resources/referrals you need.

www.cancer.org **800-227-2345**

Free financial counseling through the Financial Empowerment Centers, operated by local nonprofit m*powered* and the Denver Office of Strategic Partnerships. Get free help prioritizing what bills to pay, make a budget, deal with collectors, and more. Call **720-944-2198** or email info@mpoweredcolorado.org to schedule your free appointment. For more information about the Centers, visit: www.mpoweredcolorado.org/DenverFEC.