

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.
- 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 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 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 C-302
 Denver, CO 80222
 Phone: 303.669.3113 Fax: 303.635.3113
 grants@senseofsecurity.org



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 (circle): N/A 0 I II III IV A B C
Describe current treatment:	Diagnosis Date:
Surgery <input type="checkbox"/> Type:	Date of Surgery:
Chemotherapy <input type="checkbox"/> Begin date:	Anticipated end date:
Chemotherapy Agent(s):	
Radiation <input type="checkbox"/> Begin date:	Anticipated end date:
Hormone <input type="checkbox"/> Begin date:	Anticipated end date:
Patient insurance status: None <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> CICP <input type="checkbox"/> VA <input type="checkbox"/> Private <input type="checkbox"/> 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: <input type="checkbox"/> Utilities <input type="checkbox"/> Medical <input type="checkbox"/> Rent <input type="checkbox"/> Mortgage <input type="checkbox"/> Food <input type="checkbox"/> Transportation <input type="checkbox"/> 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: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Domestic Partnership/Civil Union <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed							
Gender identification: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Gender non-conforming <input type="checkbox"/> Other							
<i>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.</i>							
Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other							
Ethnicity: <input type="checkbox"/> African-American or Black <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> White – Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other:							
Education: <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Post-Graduate							
How, when, and where is it easiest to reach you?							
Preferred language:							
I am employed: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Self-employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> 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)							

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 (<i>bus pass, cab, or other expense</i>)	\$		
12) Gasoline and oil	\$		
13) Insurance:			
a) Health	\$		
b) Car	\$		
c) Home/renters (<i>if not included w/ mortgage</i>)	\$		
d) Life insurance for you	\$		
e) Life insurance for your family	\$		
14) Other Non-Medical bills or payments*	\$		
15) Property taxes (<i>if not included w/mortgage</i>)	\$		
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? <i>(We strongly encourage you to seek assistance from any and all agencies and resources. Assistance from other resources does not affect eligibility.)</i>	
Summarize your current financial situation (This is required) . Include as attachment as needed.	
<i>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> <i>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.</i>	
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 you are in active cancer treatment, live in Colorado, and are experiencing significant financial hardship. Ray of Hope funds can be used at the grantee's discretion.

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



RAY OF HOPE
CANCER FOUNDATION



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.



UNIVERSITY of
DENVER

CENTER FOR ONCOLOGY
PSYCHOLOGY EXCELLENCE

COPE is the first graduate-level psychology program in the country to train psychologists to work with cancer patients and survivors. It partners with community cancer centers and offers psychotherapy services to cancer patients, survivors, caregivers, and family members.

For more information call 303-871-7701 or visit www.du.edu/gsp/cope
Local cancer support groups listing at : www.du.edu/gsp/services/cope

Free financial counseling through the Financial Empowerment Centers, operated by local nonprofit *mpowered* 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.



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

Do you need food assistance?

Food Bank of the Rockies (Northern half of Colorado, including Metro Denver)

303-371-9250

www.Foodbankrockies.org

Care and Share (Southern half of Colorado)

719-528-1247

www.Careandshare.org

Community Food Share (Boulder and Broomfield counties)

303-652-3663

www.Communityfoodshare.org

Food Bank for Larimer County

970-493-4477

www.Foodbanklarimer.org

Weld Food Bank (Weld County)

970-356-2199

www.Weldfoodbank.org

Each website has a “food finder” link to locate pantries in their area. Or just call and let them know you need food assistance. Callers do not have to provide any personal information (i.e. medical condition); you simply need to state that you are in need of food assistance.

Most often, they can provide a couple of options and explain other available food options and how to get them:

- how to apply for SNAP benefits (food stamps)
- how to determine eligibility and receive CSFP boxes (seniors only)
- how to sign kids up for free/reduced breakfast and/or lunch, etc.