RMCCF
Rocky Mountain
Childhood Cancer Foundation

MEDICAL AND LIVING EXPENSES ASSISTANCE

Dear Applicant,

The Rocky Mountain Childhood Cancer Foundation (RMCCF) is a totally volunteer organization created to assist families dealing with the emotional and financial stresses of childhood cancers. Within certain limits and resources, our foundation may assist families with BOTH medical and "living expenses" while under treatment. Attached to this instruction sheet are two (2) applications. One application for medical assistance and a separate application for living expenses assistance. You are welcome to apply for both forms of assistance or either one individually.

To expedite your application and assure the greatest possibility that your application will be approved, please follow the instructions below before submitting your application for consideration.

Application Guidelines

- Applicant's child must have a diagnosis of hematologic /oncologic and be receiving active treatment.
- Applicant's child must be receiving treatment in Colorado.
- Applicants may receive assistance once in a 12-month period.
- Priority is given to applicants whose household expenses exceed household income and those that demonstrate a dire financial situation.
- Verification form must be completed and signed by a health care professional. *(Physician, Nurse, social worker, or Physician's assistant)*
- If you have circumstances not addressed within these questions or would like to provide additional comments, please attach a separate sheet with that information.
- All applications are reviewed by the members of the board for final decision.
- Referring professionals will be notified of the status of the application within 30 days.
- If approved, assistance is not ongoing; it is for one month only.
- A copy of the patient's medical records may be required.

Medical/Living Expense Application

- The applications must be fully completed and attach all copies of medical bills, co-pays, deductibles, etc.
- All information requested is entered, approximate dollar amounts.
- Living expense application is intended to primarily assist those whose parent can no longer work or whose work has been restricted because of treatment obligations. Assistances with travel to/from treatment, rent, food, daycare, etc.....
- All applications must be fully completed and attach all copies of bills for rent, utility, travel expenses, etc....

Submit completed applications to:

Rocky Mountain Childhood Cancer Foundation
8371 Southpark Lane
Littleton, CO 80120
Email: rmchildhood@gmail.com
FAX: 720.283.1244

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Medical Verification Form

Must be completed and signed by health care professional

Please fill out form completely. Print clearly and do not use abbreviations or codes for diagnosis for treatment.

Patient Name:	DOB:	Parents Name:
Name of physician:	Date of diagnosis:	
Current Cancer Diagnosis:		
Describe current treatment (include date of surgery and timeline for chemotherapy, radiation therapy, or other treatment)		
Name of referring professional:		
Address of referring professional:		
City State Zip code		
Phone ( ) Email Address		
Is the physician affiliated with RMCCF? YES NO if yes, which location?		
Is the physician affiliated with another medical entity or agency? YES NO		
If yes, please name the physician's affiliation:		
Do you have any reservations concerning this patient's request for financial assistance? YES NO		
Comments:		
Must be signed by referring professional *(Physician, Nurse, social worker, or Physician's assistant)*		
Signature:		**Date:**

Rocky Mountain Childhood Cancer Foundation

Medical/Living Financial Assistance Application

Answer each question completely

Name		Date
Address		
City	State	Zip Code
Phone Home ( )	Work ( )	Cell ( )
E-mail address		
I am (*please circle)* Married Single Separated Divorced Widowed		
I am (*Please circle)* Employed: Full time Part time Self-employed Unemployed		
How long have you worked for this employer? _____ Is your spouse/partner employed? YES NO		

List the names of all people living in your home

Name	Relationship	Age

Comments:

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APPLICATION INCOME & ASSETS

TO BE COMPLETED BY APPLICANT

Name			Date
Tell us about your current total household income			
Income		**Monthly Amount**	
1. Your monthly income from working		**$**	
2. Your spouse/partner's monthly income from working		**$**	
3. Other family member's monthly take home pay		**$**	
4. List any additional income			
4a. Child Support		**$**	
4b. Spousal support		**$**	
4c. Public assistance		**$**	
4d. Other income, Please list		**$**	
		$	
		$	
Total Monthly Income		**$**	
ASSETS		**Current Value**	**Current Loan**
1. Do you own or are you buying a home? Yes No		$	$
2. Do own or are you buying a car? Yes No		$	$
3. Checking account balance and name of bank:		$	
Bank:		$	
4. Savings account balance and name of bank:			
Bank:		$	
Circle appropriate answer.	**If yes, provide**	Value	Loan	income
5. Do you own a business or any part of a business? Yes No		$	$	$
6. Do you have any investments, stocks or bonds? Yes No		$	$	$
7. Do you own any other real estate properties? Yes No		$	$	$
8. Do you own any annuities? Yes No		$	$	$
9. Do you own "cash value" life insurance? Yes No		$	$	$
10. Do you have any other assets? Yes No		$	$	$
Note: if you answer "yes" to question #5 please provide a current balance sheet for your				

business. If you answer "yes" to questions 5-10 please provide your most recent income tax return.

APPLICATION EXPENSES

TO BE COMPLETED BY APPLICANT

Name			Date	
Monthly Living Expenses				
Expense	Monthly Payment/Amount	How Often	Total Balance	Priority of Need
1. Rent or mortgage *Payment is made to:*	$			
2. Condo fees or HOA fees	$			
3. Utilities Gas	$			
Electric Water	$ $			
4. Telephone	$			
5. Cell Phones	$			
6. Your car payment *Payment is made to:*	$			
7. Child care *Payment is made to:*	$			
8. Pet care	$			
9. Tuition	$			
10. Transportation	$			
11.Credit card payments	$			
12. Please list other expenses not listed				
Total Monthly Living Expenses				
Monthly Medical Expenses				
1. Health insurance Premiums	$			
2. Co pays	$			
3. Prescription costs after insurance	$			
4. Other medical costs after insurance	$			

Total Monthly Expenses	$			

Name

** Please describe any other expenses due to the diagnosis of your child.*

Is there anything else you would like us to know about your current financial situation?

I certify that the information provided on this application is true and accurate to the best of my knowledge. I agree to defend, indemnify and hold The Rocky Mountain Childhood Cancer Foundation harmless from any and all claims, disputes, liabilities or causes of action arising out of the agreement to provide assistance, or arising out of services or goods sold or provided to recipients of assistance through The Rocky Mountain Childhood Cancer Foundation .

Authorization/Release for Protected Health Information (PHI)

I authorize any physician, health care professional, hospital, clinic, laboratory pharmacy, medical facility or other health care provider that has provided payment, treatment or services to my child to disclose my entire medical record and any other personal health information concerning my child to Rocky Mountain Childhood Cancer Foundation (RMCCF) This includes information on the diagnosis and /or treatment of HIV infection sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco. I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it. This information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected. This Authorization shall remain in force and effect for the duration of my request for assistances from the Rocky Mountain Childhood Cancer foundation.

I have read the above and authorize the disclosure of the protected health information.

Signature of Patient/Parent/Legal Guardian: _____Date_____

Patient over eighteen (18) years of age require the patient signature:_____

Please note that falsification of any of the above information is grounds of denial of funds, or immediate termination of support upon discovery.	
Applicant's Signature	Date

FOR FOUNDATION USE ONLY:

APPROVED ☐

DISAPPROVE ☐

AMOUNT APPROVED $_____ REVIEWED BY: _____

DATE: _____

COMMENTS: _____

_____

_____