



The Sheboygan County Cancer Care Fund

The Sheboygan County Cancer Care Fund (SCCCF) is dedicated to improving the health, well-being, and quality of life for individuals and families of Sheboygan County who have been diagnosed with cancer or a disease of the blood.

1621 N. Taylor Drive • Sheboygan, WI 53081 • (920) 458-7433 • www.scccf.org

Request For Funding

The SCCCFF is supported entirely by public contributions. It is important that these limited funds be available for patients who are experiencing the greatest financial need. Listed below are some questions to consider before completing this application or requesting funding:

1. What impact has the diagnosis had on your current income or financial situation?
2. What unusual out-of-pocket expenses do you have as a result of the diagnosis?
3. What other financial resources do you have access to that may assist with these expenses?

If you believe you are in financial need at this time complete both sides of this application and return to:

The Sheboygan County Cancer Care Fund

ATTN: Tim E. Renzelmann

1621 N. Taylor Drive

Sheboygan, WI 53081

920-458-7433 (ext. 330)

Section 1: Please provide us with information about the person who will benefit from this SCCCFF Funding Request:

Last Name, First Name, Middle Initial

Date of Birth

Address

Phone Number

City, State, Zip

Social Security Number

Diagnosis/Disease/Condition

Date of Diagnosis

Physician

Phone Number

Section 2: Please provide us with information about the person making this SCCCFF Funding Request (if different from above).

Last Name, First Name, Middle Initial

Date of Birth

Address

Phone Number

City, State, Zip

Social Security Number

Relationship to above individual

Section 3: Funding Will Be Used For (please explain below):

- Payment of disease-related medicine, drugs, or treatment not covered by insurance.
- Payment of durable medical goods needed to enhance quality of life not covered by insurance.
- Personal activities to assist the recipient in maintaining a positive attitude and/or an improved quality of life.
- Other:

Section 4: Please describe in detail the purpose of requested funds:

Total Cost Of Expenses Stated Above:\$_____.

Note: The SCCCCF will make payment directly to provider. Please include all appropriate documentation (i.e., copies of outstanding bills or receipts that include name of provider, address, and balance). Copies of paid receipts are necessary in order for us to reimburse expenses already paid by an individual.

Make Check Payable To: _____

Send Check To: _____

Section 5: Does the recipient of these funds have insurance to cover any/all of these expenses?

- YES.** Insurance covers most/all of the stated expenses.
- YES.** Insurance covers this expense but my out-of-pocket cost is.....\$_____.
- NO.** No Insurance **OR** Insurance covers none of this expense.

Section 6: Does the recipient of these funds have other financial resources to cover any/all of these expenses?

- YES.** Other financial resources cover most/all of stated expenses.
- YES.** Other financial resources are available but my out-of-pocket cost is.....\$_____.
- NO.** I do not have other financial resources to cover this expense.

Section 7: Amount of Funding/Assistance Requested:.....\$_____.

Section 8: Agreement:

I am requesting this funding for (check one) **myself** **recipient listed on front of this application.** I certify that all information that I have presented in this written application is correct and true to the best of my knowledge. I agree that all funds received will be used for the purpose stated herein. I understand that I will be liable for any funds that are incorrectly used or that were acquired through intentional misrepresentation. I understand that the approval of funding may be contingent upon my financial need.

Print Name Of Person Completing This Form

Date

Signature Of Person Completing This Form

Approved by _____ Denied by _____ Amount: \$_____ Check # _____ Date: ____/____/____
Comments: