Southeastern Cancer Care is a non-profit organization established to assist cancer patients who live in Eastern North Carolina.

Assistance Qualifications:

- Applicants must be actively undergoing treatment, as defined by chemotherapy or radiation or be within three months of an oncology related surgery.
- Live east of Interstate 95 or the counties that have Interstate 95 within their boundaries.
- Assistance will be based on the income of the individual or family according to the poverty guidelines published annually by the government which are effective on January 1 of each calendar year. Assets are not used to determine the level of assistance received.

If you meet the above qualifications, we encourage you to apply as soon as possible.

Please allow up to 72 hours after submission for review. We are not an emergency fund and cannot provide immediate assistance.

All of the below items are required for consideration, please submit all necessary documentation. Incomplete applications will not be accepted.

-Completed SCC application, please do not leave any demographic information blank.

-Proof of Income, please submit **one** of the following:

* W-2's, 1099's or schedule C's (please do not submit originals)
* 3 months of consecutive pay stubs or letter from each employer on company letterhead attesting to employment and compensation for each member in patients household
* Copy of applicants most recent bank statement

If you are **NOT** a patient of Southeastern Medical Oncology Center, please provide the information below with your application.

-A signed and dated letter (on letterhead) verifying your current diagnosis and detailing your treatment plan from one of the following: Oncologist, LCSW, Patient Navigator, or Nurse Navigator.

Please submit completed application, and all materials listed above to cfc@cancersmoc.com. You can also call 919-587-9056 with any questions.

* Southeastern Cancer Care can assist beneficiaries with the following: fuel cards, grocery certificates, household utility payments and oncology prescribed medications.
* Utility bills must be submitted to a SMOC location Please refrain from contacting the organization regarding your bill during the requested ten day grace period.
* If you are not a patient of SMOC, utility bills must be submitted by an LCSW, Patient Financial Counselor, Patient Navigator or Nurse Navigator.

SOUTHEASTERN CANCER CARE
Cures for the Colors

Southeasterncancercare.org

Personal Information

Name (First, Middle, Last) _____

Street Address _____

City _____ Zip _____

E-mail Address _____

Diagnosis (What type of cancer do you have?) _____

Date of Birth _____

Treatment Plan (chemo, radiation, surgery, etc) _____

Marital Status SINGLE MARRIED WIDOWED # Of Dependents _____

Home Phone _____ Mobile Phone _____

Gross Monthly Income

Income	Monthly	Spouse	Yearly
Salary	_____	_____	_____
Pension	_____	_____	_____
Social Security	_____	_____	_____
SSI Supp Income	_____	_____	_____
Disability	_____	_____	_____
Unemployment	_____	_____	_____
Alimony/Child Support	_____	_____	_____

Authorized Individuals

(Please list below who you would like to authorize on your behalf to work with the organization.)

_____ _____ _____

(*First and Last Name*) (*Relationship*) *(Phone Number)*

_____ _____ _____

(*First and Last Name*) (*Relationship*) *(Phone Number)*

By my signature below I attest that the information provided herein is complete and accurate. I understand that I may be required to provide additional information and documentation upon request for the purpose of determining my eligibility for assistance through Southeastern Cancer Care. I agree to inform Southeastern Cancer Care of any change of condition or circumstances that might impact my eligibility. Any untruthful or fraudulent information provided or my refusal to cooperate with the eligibility process may be grounds for denial of assistance or termination from the program. I also understand the above information may be provided to pother third party patient assistance programs on my behalf.

Applicant Signature: _____ Date: _____ / _____ / _____

Internal Use Only

Submission Date: _____ / _____ / _____

Approved for: $_____

Effective Date: _____ / _____ / _____

Expiration Date: _____ / _____ / _____

Type of Cancer:_____

Treatment:_____

Signature: _____

SOUTHEASTERN CANCER CARE

Cures for the Colors

Southeastern Cancer Care

Grant Agreement

I understand I must meet all eligibility guidelines including being on active treatment as defined by chemotherapy, radiation, or within 3 months of an oncology-related surgery.

I understand this grant is for the term of six months and is for the amount of $750.

I understand that this grant will last up to six months **or** until the funds are exhausted, whichever comes first.

I understand that if I exhaust my grant funds before the six month term is up, I will not be eligible for any additional funding until I am eligible to reapply for the grant.

I understand that I will have to reapply for this grant every 6 months.

I understand that if I am requesting assistance with my utility bills I must submit them to the Community Development Coordinator at least 10 business days before the due date.

I understand that I am only allowed one form of assistance each week unless I choose the every two-week option for gas and grocery cards

Signature: _____ Date: _____