VCS Cancer Foundation

The VCS Cancer Foundation requires that applicants for our Rainy Day Gifts program work with a social worker or health care professional (oncologist, oncology nurse) to complete the application. The application will require information and signatures from both parties.

Applicants must currently be receiving active cancer treatment (e.g., radiation therapy, chemotherapy, immunotherapy, bone marrow transplant, surgery) in the Northern Virginia area (Arlington, Fairfax, Loudon, Prince William counties and all of the cities within these counties, and the city of Manassas) and provide proof of financial need.

The completed medical information, patient information and patient release forms can be mailed or scanned and emailed to the VCS Cancer Foundation at:

VCS Cancer Foundation
PO Box 194
Herndon, VA 20172

info@vcscancerfoundation.org

The Bill Payment Form should be mailed after the patient has received notice that the gift application has been approved. Bills must be received *at least two weeks before their due date*; the VCS Cancer Foundation is not responsible for late fees, interest or account closures associated with failing to pay a bill on time.

We will not process incomplete applications. Applications will not be processed until all required items and signatures have been received. Applications will be evaluated on a first come, first served basis. Rainy Day Gifts will be awarded based on available resources and are limited to one per patient.

Patients will be notified regarding whether their application has been approved. Once patients receive an approval letter, they must complete the Bill Payment Form to indicate how they would like to receive their gift. Patients who would like payment of rent, utility or cell phone service bills must submit copies of these bills or a copy of the rental agreement. Bills for rent, utilities or cell phone service must be in the patient's name or spouse's name, or must be for living expenses at the patient's current address. For these payments, checks will be made payable directly to the landlord, utility company (e.g., Dominion Virginia Power) or cell phone service provider and will be sent to the patient to submit to the vendor. Patients may also choose to receive all or part of their gifts in the form of supermarket gift cards. Patients may use their gift for any combination of bills and supermarket gift cards as long as the total does not exceed the approved gift amount.

Please address any questions or concerns to us via email at: info@vcscancerfoundation.org

VCS Cancer Foundation

MEDICAL INFORMATION
To be completed by a health care professional

Patient Information

First Name ________________________ Last Name _________________________________

Date of Birth ____________________ Gender: M____ F ____
Marital Status (optional): Married ____ Single ____ Divorced ____ Widowed ____

Diagnosis _____________________________ Stage ____ Date of Diagnosis ______________

Current Treatment (check all that apply)

_____ Chemotherapy Date of Last Treatment __________________
_____ Radiation therapy Date of Last Treatment __________________
_____ Bone Marrow Transplant Date of Last Treatment __________________
_____ Immunotherapy Date of Last Treatment __________________
_____ Surgery Date of Last Treatment _________________

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THE SIGNATURE OF THE TREATING ONCOLOGIST, ONCOLOGY NURSE OR MEDICAL SOCIAL WORKER IS REQUIRED HERE:

I attest that the patient named here has been diagnosed with cancer and is currently receiving treatment as stated above.

X____ Date ____________________

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Clinic Information

Oncologist ______________________________________
Address ____ City ________________________
State ___________ Zip Code ____________ Phone __________________________

Health Care Professional Information

Name ____ Phone __________________________
Clinic Name ____
Address ____
City ________________________________ State ________________ Zip Code ______________
Email ____

PATIENT INFORMATION

First Name _____ Last Name _____

Address _____ City _____

State _____ Zip Code _____ County _____

Email _____ Phone _____

How would you like to receive information regarding your application?
_____ Phone _____ Email _____ Mail

Can we leave a voicemail message on your phone? ____ Yes ____ No

Please check all of the following that apply to you:

I am a Medicaid recipient Yes _____ No _____
If Yes, please include a copy of your Medicaid card

I have a Charity Letter from a hospital or clinic Yes _____ No _____
If Yes, please include a copy of your Charity Letter

My children get free or reduced lunch at school Yes _____ No _____

If you responded "No" to all three statements above, please provide evidence of need from a financial counselor, social worker or office manager in your medical treatment office.

All of the information in this application packet is true to the best of my knowledge.
I understand that applications are reviewed on a case-by-case basis and the final determination of any financial gift is made by the VCS Cancer Foundation.
I hereby give my permission to have this application and all information provided herein shared with the VCS Cancer Foundation and grant that it may be discussed with my health care professional. All of the enclosed information will be kept confidential.

Patient Signature _____ Date _____

Printed Name _____

How did you hear about the VCS Cancer Foundation? Check all that apply.
_____ Social Worker _____ Nurse _____ Oncologist _____ Internet
_____ Patient Navigator _____ Brochure _____ Patient Financial Counselor

_____ Other (please specify) _____

BILL PAYMENT FORM

This form, along with any required attachments (see below), should be submitted after the patient's grant application has been approved. Bills must be received at least two weeks before their due date. The VCS Cancer Foundation is not responsible for late fees, interest or account closures associated with failing to pay a bill on time.

Patient Name: _____

The VCS Cancer Foundation's Rainy Day Gifts may be used for payment of rent, utility, cell phone bills and for supermarket gift cards. Your gift of $400 may be allocated to more than one category, but cannot exceed $400 in total. Please indicate below how you would like to receive your gift *once your application is approved*.

- Copies of utility bills must be attached
- For rent payments, a copy of the first page of the lease or letter from the landlord indicating the rental payment amount must be attached
- Checks will be made payable to the vendors (landlord, utility company, cell phone service provider)
- Checks will be sent to the patient to forward to the vendor
- Gift cards will be sent to the patient

Name of Vendor *Example: Dominion Power*	**Type of Bill** *Example: Electric*	**Amount to be paid** *Example: $125.24*
1.		**$**
2.		**$**
3.		**$**
4.		**$**

Giant Supermarket Gift Card Amount Requested _____