ORION Cancer Foundation

GRANT GUIDELINES

The O'Callaghan Resource Integrated Oncology Network (ORION) Cancer Foundation was established to provide financial assistance to cancer patients for basic living necessities. ORION support helps reduce the stress created while trying to manage everyday expenses along with medical bills. The ORION Cancer Foundation is an adult funding program of the Nevada Childhood Cancer Foundation (a nonprofit, 501 c 3 organization).

Eligibility Criteria

Eligible applicants ***may receive funding NOT to exceed $1500, in a 12-month period, toward household bills (rent, mortgage, utilities, & COBRA will be considered).*** **Medical expenses are NOT paid (with the exception of the initial screening mammogram for uninsured individuals).** Bills are paid directly to the addresses provided on bills submitted. Applications are accepted once in 12-month period per individual. Assistance is available for:

- Patients who are currently receiving medical treatment for cancer in Southern Nevada
- Those who demonstrate diagnosis related financial hardship
- Applicants who are at least 18 years of age. If the patient is a minor, a parent/guardian must complete the application on the minor's behalf

Application Process

Applications for assistance are accepted once within a 12-month period. Completing a grant application does NOT guarantee funding. Application are available at www.ORIONcancerfoundation.org and may be submitted attention to ORION Cancer Foundation by:

- **Mail: c/o NCCF, 6070 S. Eastern Ave., Ste. 200, Las Vegas, NV 89119**
- **Email: info@ORIONcancerfoundation.org**
- **Fax: 702.735.8431**

Please include the following documentation with your application:

- ☐ Letter on physician's letterhead verifying current cancer diagnosis/treatment
- ☐ Grant Request Personal Data (Page 2)
- ☐ Grant Request Worksheet (Page 3)
- ☐ All back-up documentation on Grant Request Worksheet (Page 3)
- ☐ Grant request Signature Page (Page 4)

Applications are not considered COMPLETE without ALL required documentation and applications will not be reviewed until complete.

ORION Cancer Foundation

PERSONAL DATA

Fill out completely. Please print clearly.

Applicant Name or Parent(s)/Legal Guardian(s)						
Address			City		State	Zip
Email		Age		Marital Staus		
Home	Work		Cell			
Please circle employment status:	Full Time	Part-time	Self-Employed	Unemployed	Retired	
Have you applied for disability: (Yes or No)		Date:	Approved:	Yes or No	Date	
Employer			Date last worked:			
Address		City		State		Zip
Is your spouse/partner employed?: (Yes or No)		Employer's Name				
Address		City		State		Zip
Do you have breast cancer? (Yes or No)		No If not, what type of cancer?				
Patient referred by		Name of oncologist (cancer physician):				
List the names of all people living in your home:						
Name	Relationship	Age	Employer			

Adult children (ages 18 and over) living in the home are NOT considered dependents unless they are full-time students. Proof of full-time school attendance will be required.

Briefly explain your current financial hardship due to diagnosis:

ORION Cancer Foundation

GRANT REQUEST WORKSHEET

Back up documentation <u>required</u> for funding consideration.
Applications will be rejected if this information is not included.

Provided	*Income*	*Amount*
□	Your total gross monthly salary (pay stubs or tax return)	$
□	Your spouse/partners gross monthly salary (paystub or tax return)	$
□	Disability	$
□	Social Security	$
□	Retirement/Pension/Death Benefit	$
□	Child/Spousal Support	$
□	Food Stamps	$
□	Other Income- Please explain	$
□		$
□		
	Total Gross Monthly Income	**$**

	Average Monthly Expense	*Amount*
□	Rent or Mortgage (mortgage statement or lease agreement)	$
□	Utilities	$
□	Power	$
□	Gas	$
□	Water	$
□	Trash	$
□	Sewer	$
□	Child Support (court order or paystub)	$
□	Car Payment	$
□	Car Insurance	$
□	Other Transportation (bus passes)	$
	Fuel (Average no backup required)	$
□	Health Insurance/COBRA	$
	Groceries (Average no back up required)	$
□	Medical Bill deductibles/remaining balance due	$
□	Other Expenses- Please explain	$
		$
		$
		$
		$
	Total-Average Monthly Expenses	**$**

Please list the requested financial assistance below individually.

		$
1.		$
2.		$
3.		$
4.		$
5.		$
	Total Financial Assistance Requested	**$**

ORION Cancer Foundation

GRANT REQUEST SIGNATURE PAGE

Back up documentation required for assistance. Please note applications will be automatically rejected if information is not attached.

Please initial, signature, and print where applicable below:

I understand that completing and submitting an application does NOT guarantee funding:_____
Initial

I understand that my application, to be considered for funding, must include all required documents:_____
Initial

I certify that the information provided on this application is true and accurate to the best of my knowledge:_____
Initial

I release the ORION Foundation, Nevada Childhood Cancer Foundation, and all related subsidiaries of all liabilities or claims arising out of the assistance of services provided to me or my family. I authorize the ORION Foundation 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 give permission for (name)_____my (spouse, sibling, friend, partner, etc.) _____ to speak to the ORION Foundation on my behalf.

_____ _____
PRINT NAME: Applicant or Parent/Legal Guardian Date

_____ _____
SIGNATURE: Applicant or Parent/Legal Guardian Date

How did you hear about the ORION Cancer Foundation?_____

_____

Reminder: Only complete applications, which include all requested and required documents, will be reviewed for funding.

FOR FOUNDATION OFFICE USE ONLY: Date Received:_____

Date Reviewed:_____ Date Approved or Denied (circle):_____Grant Amount:_____