APPLICATION FOR CIRCLE OF VICTORY GRANT

The Circle of Victory (COV) Fund underwrites financial assistance for patients facing cancer and receiving treatment at a Greene County Kettering Health Network (KHN) facility. (Greene County residents receiving treatment at KHN facilities outside Greene County or non-KHN facilities are considered on a case by case basis.) Financial assistance to patients via approved grants can include, but is not limited to, assistance for cancer treatment or conditions associated with treatment, medication, wigs, and prostheses, paid directly to providers not in direct competition with Kettering Health Network.

Completed applications with appropriate documentation for all requested assistance attached can be faxed to 937-352-3230 or mailed to:

Greene Medical Foundation
1141 N. Monroe Dr.
Xenia, OH 45385

If information is incomplete, the Foundation will ask for further explanation/documentation, thus slowing processing. Only properly completed applications are presented to members of the Greene Medical Foundation's Grant Committee for approval. Under no circumstance will the Foundation reveal Grant Committee members. The Foundation will notify you of their decision by phone or mail. Assistance will be paid directly to a vendor/provider and not to the applicant.

==

Patient Name:____

Address:____

City/State/Zip:____

Telephone Number:____

Email:____

PERSONAL INFORMATION (present copy of cards):

1. Insurance:____
2. Medicaid:____
3. Medicare:____
4. Receiving treatment at what facility:___________________________________
5. Attending Physician:____

REQUEST FOR ASSISTANCE OF (check all that apply):

- ☐ Cancer treatment prescribed by attending physicians
- ☐ Conditions associated with, or as a consequence of, treatment, as determined by attending physicians
- ☐ Prosthesis and Prosthetic wigs
- ☐ Medication
- ☐ Associated counseling during cancer treatment and prescribed for cancer management

AMOUNT REQUESTED ($1,500 maximum): $ ________________________

Please include all documentation, quotes, invoices, bills, etc. that pertain to the financial request. You may be asked to verify financial need.

Please describe why you need financial assistance for the above requested items:

____

____

____

____

____

____

____

____

I, ____________________________ hereby authorize the Greene Medical Foundation to contact my treatment center to validate treatment and my insurance company to verify benefits.

____________________________________ ____________________________

Signature of Applicant Date

____________________________________ ____________________________

Signature of Individual Completing Application Date

==

<u>CIRCLE OF VICTORY GRANT COMMITEE USE ONLY</u>

____

Approved Signature Date

____

Approved Signature Date

____

Approved Signature Date