

SOUTH LAKE TAHOE CANCER LEAGUE
LIMITED FINANCIAL ASSISTANCE GRANT APPLICATION

The **SOUTH LAKE TAHOE CANCER LEAGUE (SLTCL)** offers limited needed financial aid to cancer patients who are in **ACTIVE TREATMENT** (i.e. NOT in remission, NOT “being followed after treatment”, NOT on Hospice).

In order to be eligible for this grant, the cancer patient **MUST** be a permanent resident of the area from the El Dorado/Placer County Line, CA - on the west through the south shore of Douglas County Line/Stateline Lake Tahoe to Glenbrook, NV - on the east. Repayment of this grant is not required nor is membership.

GRANT CONDITIONS APPLY:

1. The patient must be under current **ACTIVE** medical treatment for **cancer**. This treatment must be under the direct supervision of a physician licensed to practice medicine in either the States of California or Nevada. This does not include the periodic monitoring of the remissive disease. Patients receiving chemotherapy or radiation therapies and/or surgeries including colon, lung, breast, prostate, etc... are examples of cancer patients in “active treatment”.
2. Upon the recommendation of the attending physician treating you for cancer (not your general practitioner).
3. An application must be signed by both the patient and the attending physician and either Faxed by the physician to the **SOUTH LAKE TAHOE CANCER LEAGUE** or mailed by the patient. We accept applications by mail or fax. If Faxed, the patient and attending physician’s doctor must sign the grant application and the doctor sends the fax with their coversheet.
4. A new **ORIGINAL** application must be submitted every two (2) months if a patient wishes to reapply. SLTCL should receive subsequent applications one week prior to the expiration of the previous grant. Early submission will not speed up the process.
5. Patient may submit a new application for a maximum period of 18 months following initial diagnosis or surgery. If any repeat Grant Application is received after the 18 month expiration date, each grant will be reviewed, voted on by the Board of Directors of SLT Cancer League, and each applicant will be notified of the Board’s decision.

SLTCL will consider all grant requests meeting the required conditions as stated above without regard to race, ethnicity, color, age, religion, national origin, disability, sexual orientation, sex or marital status. SLTCL reserves the right to approve or deny a grant request based ONLY on the information provided by the patient and attending physician.

By signing below patient authorizes the SLTCL to verify eligibility based on the criteria listed above. SLTCL respects patients’ rights and HIPAA privacy laws and will determine the amount of any grant and the frequency of availability based on fair and confidential need to know practices. This program may be changed or discontinued at any time without notice. Recipients may **also** qualify for additional services provided by the SLTCL simultaneously with this grant (i.e. transportation to treatments from the SLT area to UC-Davis/Sacramento, Truckee, Reno, Carson City, Gardnerville and Minden). Please call us for more information about our community services.

PATIENT INFORMATION: *If you are a VA or UC-Davis patient, please provide your medical ID#:* _____

Date of Birth: _____

Patient’s Name: _____ **Telephone:** _____

Physical Address: _____

Mailing Address: _____

Type of Cancer: _____

Attending Physician’s Name: _____ **Telephone:** _____

Physician’s Mailing Address: _____

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Both Patient and Physician's signatures below certify that all statements made on this application are true, complete and correct to the best of Patient and Physician's knowledge. Furthermore, it is understood that these statements are subject to verification and no guarantee is made by the SLTCL or the referring physician. It is understood that falsification on this application will disqualify the cancer patient from all SLTCL benefits.

Signing below is a direct authorization for the release of any pertinent medical information pertaining to the patient's current cancer treatment(s) for the sole purpose of the SLTCL to determine the patient's eligibility to receive said grant approval. All parties hold one another, board members and the SLTCL organization harmless from any liability regarding the limited grant approval process.

PATIENT'S SIGNATURE: _____ **DATE:** _____

**CANCER TREATING
PHYSICIAN'S SIGNATURE:** _____ **DATE:** _____

Optional notes, comments, or special circumstances & duration of treatment:

(Physician's office: Please retain a copy of this signed Limited Financial Assistance Grant Application, if the patient is mailing the original application, or place the original in the patient's file if you are faxing).

For Further information and availability of other services, please contact us:

SOUTH LAKE TAHOE CANCER LEAGUE
P.O. Box 17962, South Lake Tahoe, CA 96151
Telephone: (530) 573-1703 Email: sltcancerleague@gmail.com
FAX (877) 630-0109

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For SLTCL Use ONLY
ELIGIBLE AGAIN ON: _____

President's Signature (SLTCL): _____ Date: _____

Approved: _____ Denied: _____ Date: _____ Amount: _____

Treatment: Surgery _____ Radiation _____ Chemotherapy _____ Other/Type _____

