Cancer Outreach and Community Hope:

A Local Charity serving Coosa County, Alabama

"Assisting Patients through Their Journey to Recovery"

**Assistance Request Application

COACH Mission Statement:

To assist citizens of Coosa County cancer patients currently undergoing debilitative cancer treatments by providing temporary financial assistance for basic needs such as rent/mortgage and utilities.

The basis for this critical assistance will come from corporate donations, private donations, grants and certain fundraising efforts.

Patients are chosen through a selection process that addresses specific needs. Once a recipient is chosen, funds will be disbursed directly to the vendor or supplier of these identified needs based on the availability of funds. Our goal is to assist these patients in winning their battle against cancer. By diminishing financial stress related to the basic needs of the family, patients can direct their energies more effectively to the healing process.

** Policy & Eligibility Guidelines for Assistance:

Our objective is to assist as many Coosa County cancer patients as possible. To ensure this, we have established certain policies and guidelines. (These guidelines will be reviewed and updated annually by our Board of Directors).

**General Requirements:

1. Must be a resident of Coosa County.

2. Must be currently undergoing cancer treatments. Treatments defined as Chemotherapy, Radiation , Surgery or within 90 days of surgery (Diagnosis Confirmation Form must be completed and signed by both Patient and treating Physician).

3. Applications will be reviewed by COACH'S Board Directors.

4. Applicants may re-apply for assistance every 90 days from the date of award notification. If denied, cancer patient may re-apply after 30 days from date of notification letter.

Contact COACH to re-apply. 15019 US Hwy 280 Sylacauga, AL 35150

**Procedure for Assistance Request:

1. Complete and submit the Application for Assistance Request Form and all required attachments.

Applications will not be considered complete and reviewed until ALL supporting documentation is received or an explanation is received explaining any missing documents.

2. Complete the patient portion of the Diagnosis Confirmation Form and submit to your current treating physician's office. The doctor will send the Diagnosis Confirmation Form directly to COACH.

3. The Board of Directors will review all applications for assistance and will make final selection based on availability of funds.

4. Selected applicants will be notified within 10 days once assistance is approved.

5. Applications will only be accepted by MAIL. Please mail to:

COACH 15019 U S Hwy 280 Sylacauga, AL. 35150

** PATIENT CHECKLIST

Completed Application

Copies of Rental Lease or Mortgage Coupon

Copies of Most Recent Utility Statements Most Recent Tax Return

Last Pay Stub for Patient and Spouse/Significant Other

3 Months Checking & Savings Statements

Sign and Complete Disclosure of Protected Health Information

MAIL Application & Documents

Verify Doctor has Faxed in Diagnosis Confirmation form.

Web: www.coosacoach.org, e-mail: dmitchell@CoachCoosa.org

** Application for Assistance Request

Date _____/_____/_____

Applicant's Name

_____

Mailing Address _____

County _____

Home Phone _____ Cell Phone _____ Other Phone _____

Currently employed? Y or N Where? _____ Hours worked per week _____

Applicant's Total Monthly Income _____ (Payroll, Investment, Social Security, Unemployment)

Other Household Income Y or N, List Source of Income & Amount

_____

Number of Adults in Household _____ Explain

_____

Number of Children in Household ____ Others in Household

_____

Checking Accounts? Y or N How Many _____

Estimated Balance _____

Savings Accounts? Y or N How Many _____

Estimated Balance _____

Contact Person: (If Other than Patient)

_____

Mailing Address:

_____

Home Phone: _____ Cell Phone: _____

Other Phone: _____

**Name of Mortgage Co/Landlord_____

Address _____

Amount of Mortgage or Rent _____

Number of payments past due:_____

Account Number _____

Phone Number_____

**Name of Electric Company _____

Amount past due_____

Street Address _____

Account Number _____ Phone Number_____

**Name of Gas Company _____

Amt past due _____

Address _____

Account Number _____Phone Number_____

**Name of Water Company _____

Amount past due _____

Address _____

Account Number _____ Phone Number _____

**Attach copies of recent mortgage/rent coupon, electric bill, gas bill and water bill,

If selected for an award, in what order would you like any award applied (rent/mortgage, electric, gas, water)

1) _____ 2) _____ 3) _____ 4)_____

Please include a brief statement telling us about your personal situation. Include any information you feel is pertinent to your application and why you need our help.

_____
_____
_____
_____
_____
_____
_____
_____
_____

How did you hear about COACH? _____

** Please attach the following documents:

Tax Return for last year (All schedules attached)

Last Pay Stub (Patient and spouse/significant other)

Previous 3 months of checking/savings account statements

I understand that my application cannot be processed until I have completed all of the documentation and submitted it to the address noted on the bottom of this application.

By signing below, I agree that the information provided above and in the attachments is accurate to the best of my knowledge. I further understand that my name and personal/financial information will be kept confidential unless I give specific permission otherwise.

Applicant's Signature: _____ Date:_____/_____/_____

**Diagnosis Confirmation Form

Applicant's Name: _____

Complete Mailing Address: _____

Date of Birth: _____

I hereby authorize _____ (Name of Current Treating Physician) to release or disclose to COACH my medical information pertaining to my current diagnosis and prognosis, surgeries and treatments. I further authorize you to discuss with COACH any confidential information with respect to my medical condition or treatment and any confidential information with respect to my financial situation. I understand the purpose of this disclosure is for use in pending application for financial assistance by COACH. I understand that my name, personal, financial and medical information will be kept confidential unless I give specific permission otherwise. This authorization will expire one year after the date of signature below.

Applicant's Signature:_____ Date:_____/_____/_____

Patient fills out top portion of form and gives to current treating physician

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Physician fills out bottom portion of form and mail form to COACH 15019 US Hwy 280 Sylacauga, AL 35150

Type of Cancer_____

Date of Initial Cancer Diagnosis _____/_____/_____/ Date of Surgery _____/_____/_____

Chemo Start Date _____/_____/_____ Chemo End Date ____/_____/_____/

Radiation Start Date _____/_____/_____ Radiation End Date _____/_____/_____

Treating Physician Name: _____

Complete Address: _____

Phone Number: _____

Physician Signature: _____ Date_____/_____/_____

A Local Charity Serving Coosa County, Alabama, A 501(c)(3) Organization

Web: www.coosacoach.org, e-mail: dmitchell@CoachCoosa.org (256) 249- 3128