Applying to Inner Circle Foundation

Inner Circle Foundation helps those affected with rare and/or aggressive cancers for those that live in Colorado, as well as their caregivers. We customize our grants based on the information we receive from medical professionals and patients. These items include, but are not limited to, financial assistance, house cleaning, hospital grade air purifiers, holistic healing, and memory vacations.

Eligibility

- I am a Colorado resident
- I have a cancer diagnosis that is rare and/or aggressive

Checklist

- I attached a copy of my photo I.D.
- I have attached copies of 1st and 2nd priority bills (if asking for financial assistance)
- A healthcare professional that is knowledgeable about my diagnosis and treatment has completed and signed page 1 of this application
- I have signed this application

Applications can be submitted the following ways:

- Upload application on our website: www.innercirclefoundationcolorado.org
- By Email: icfdenver@yahoo.com
- By Mail: Inner Circle Foundation, 4865 S. Jericho Court, Aurora CO, 80015

Inner Circle FOUNDATION

Grant Application

MEDICAL VERIFICATION FORM – TO BE FILLED OUT BY REFERRING MEDICAL PROFESSIONAL

**Do not use abbreviations or codes for diagnosis and treatment.*

Application Date:	
Patient/Caregiver Name:	
Parent/Guardian Name (if patient is under 18):	
Cancer Diagnosis: Stage:	Date of Diagnosis:
Is patient's diagnosis considered (check all that apply): Rare ☐ Aggressive ☐ Late stage ☐ Terminal ☐	
Describe Current Treatment:	Name of Physician:
Surgery ☐ Date of Surgery:	
Chemotherapy ☐ Begin Date: Anticipated End Date:	
Other Treatments: Radiation ☐ Begin Date: Anticipated End Date: Hormone ☐ Begin Date: Anticipated End Date: Other ☐ Please List:_____	
Has the patient applied to ICF before? YES NO	
If yes, when?	
Is the patient currently able to work? YES NO	If no, what date will patient return to work?
Is patient disabled? YES NO	Date of Disability:
Patient insurance status: Private Insurance ☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Underinsured ☐	
What are patient's needs: Financial Assistance ☐ Mental Therapy ☐ Food ☐ Home Cleaning ☐ Air Purifier ☐ Spa/Holistic Healing ☐ If financial assistance, please check all that apply: Rent ☐ Mortgage ☐ Hotel/Other Housing ☐ Food ☐ Medical ☐ Transportation ☐ Other ☐ :_____	
Name of referring professional (health care professional completing form):	
Facility Name: Address: City: State: ZIP:	
Phone: ( ) Email:	
Do you have any reservations concerning this patient's requests for assistance through ICF: YES NO	
Referring professional's summary regarding need for assistance: (**This is required, please include attachment if needed)**	
Must be signed by referring professional (physician, case worker, patient navigator, social worker, nurse**)**	
My Signature below affirms the diagnosis and treatment information as described on this page:	
Signature:	Date:

Inner Circle FOUNDATION

Grant Application

PERSONAL DATA FORM – TO BE FILLED OUT BY PATIENT/CAREGIVER

Application Date:	
Parent/Guardian Name (if patient is under 18):	
Address:	City:
State/Zip:	County:
Phone Home ( ) Work ( ) Cell ( )	
Email Address:	
Additional contact person with whom we may discuss your application	Name:
Phone #:	Email Address:
How, When and Where is the easiest to reach you?	
Preferred Language:	
Cancer Diagnosis: Stage:	Date of Diagnosis:
Describe Current Treatment:	Name of Physician:
Surgery ☐ Date of Surgery:	
Chemotherapy ☐ Begin Date: Anticipated End Date:	
Other Treatments: Radiation ☐ Begin Date: Anticipated End Date: Hormone ☐ Begin Date: Anticipated End Date: Other ☐ Please List:_____	
Has the patient applied to ICF before? YES NO	If yes, when?
Is the patient currently able to work? YES NO	If no, what date will patient return to work?
Is patient disabled? YES NO	Date of Disability:
What are patient's needs: Financial Assistance ☐ Mental Therapy ☐ Food ☐ Home Cleaning ☐ Air Purifier ☐ Spa/Holistic Healing ☐ If financial assistance, please check all that apply: Rent ☐ Mortgage ☐ Hotel/Other Housing ☐ Food ☐ Medical ☐ Transportation ☐ Other ☐ :_____	
Patient insurance status: Private Insurance ☐ Medicare ☐ Medicaid ☐ Uninsured ☐ Underinsured ☐	
Additional Comments/ Requests:	
I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Inner Circle Foundation to obtain from the individuals, business, organization, agencies or entities listed in this application whatever information is necessary about my case that might be helpful for assessing my application. I release Inner Circle Foundation of all liabilities or claims arising out of the donation of service or money provided to me or my family and/or caregivers.	
Patient/Applicant Signature:	Date:

PERSONAL DATA FORM CONTINUED – TO BE FILLED OUT BY PATIENT/CAREGIVER

If asking for financial assistance, please list your household's expenses for this **month** so that we have an accurate picture of your financial situation.

Prioritize your expenses in the "Priority Need" column with #1 being the most important expense.

Attach copies of your first and second top priority bills.

EXPENSES	AMOUNT	TOTAL BALANCE	PRIORITY OF NEED	PAST DUE: YES OR NO
Rent/Mortgage Payment is made to: _____	$			
Food	$			
Medical Costs	$			
Car Payment	$			
Gas/Ride Share	$			
Child Care	$			
Utilities	$			
Credit Card	$			
Other	$			

ADDITIONAL FINANCIAL DETAILS: