Healthy Acadia
Building vibrant communities for over 20 years

Beth C. Wright Cancer Resource Center

MCF Maine Cancer Foundation
HERE FOR tomorrow

<table>
<tr><td colspan="4">The Colorectal Cancer Screening Support Fund (CCSSF) is here to lend a helping hand if the cost of getting screened for cancer or transportation to the screening is stopping you from being able to go. We offer a one-time grant of up to $1,000 to make sure you can get the screening you need. To qualify for the grant, you need to show a specific need for it, and the money must be paid directly to the vendor or service provider who will help you. We want to make sure you have the support you need to take care of your health!</td></tr>
<tr><td>Date of request:</td><td colspan="3">Date funds needed by:</td></tr>
<tr><td colspan="2">Name of applicant:</td><td colspan="2">Date of birth:</td></tr>
<tr><td colspan="4">Address:</td></tr>
<tr><td colspan="2">City/Town:</td><td colspan="2">Zip Code:</td></tr>
<tr><td>Telephone:</td><td colspan="3">Email Address:</td></tr>
<tr><td colspan="4">Amount requested: ______________ (max: $1,000) to meet the following need(s):
☐ Screening (FIT tests) ☐ Screening (Cologuard) ☐ Transportation
☐ Childcare/Elder Parent Care ☐ Other</td></tr>
<tr><td colspan="4">Please provide specific details on the screening test and/or support needed to access screening and how this financial support will help you (use additional pages if needed).</td></tr>
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How do you pay for health care (select all that apply):* ___ No Insurance ___ MaineCare (Medicaid) ___ Health Insurance (e.g. private insurance) ___ Medicare ___ Veterans Administration ___ Indian Health Services ___ Other: ___________________________ **The information you provide is only used to determine grant eligibility and will not be shared with anyone outside of the CCSSF.*	
Service providers/vendors are paid on behalf of the applicant. Grants are not given directly to applicant. Please contact the service provider/vendor who will provide this service to request a written proposal or estimate of the cost of service and obtain permission for a representative of CCSSF to speak directly to this person on your behalf. You must include the written proposal or estimate provided by the vendor or service provider with this completed application. Please initial the line below and provide the service provider/vendor's contact information. __________ Applicant's initials verifying that a CCSSF representative has permission to speak with the chosen service provider/vendor and referring organization (if applicable).	
Service provider / vendor name:	
Service provider address	Phone:
Person completing form:	Phone:
Relationship to applicant:	
Referring organization / agency (if applicable):	
Referring organization / agency contact person:	Phone:
Are the applicant and referring organization (if applicable) willing to remain in contact with the CCSSF to see how things worked out? ☐ Yes ☐ No	
Signature of applicant (verifying accuracy of the information contained in this application):	

Please mail your completed application to: Cancer Patient Navigator, Healthy Acadia, 121 Court Street, Machias, ME 04654 or by fax: 207-255-3000, Questions? Contact our Cancer Patient Navigator at 207-255-3741, Ext. 103.