APPLICATION GUIDELINES:

- Tough Enough to Help Cancer Fund is for Fremont County residents who are currently receiving treatment due to **active** cancer.
- Up to $750.00 is available for household expenses and/or travel in a 12 month period. **ONLY 2** assistance grants will be honored.
- Obtain an application from Help for Health, Fremont County Public Health or your medical provider.
- Complete application.
- **APPLICANT** must sign application, if physically able. **NO** application will be accepted without applicant's signature. If applicant is not able to sign, medical personnel may indicate why applicant is unable to sign.
- Professional referral may be a nurse, doctor or other medical staff from a medical institution, which is involved in the treatment of applicant's care, or the referring medical provider to this fund.
- Application must be accompanied by proof of residency. This can be a bill, or something mailed to the client showing they are a Fremont County resident. This fund is only available to Fremont County residents.
- Authorization to release information is **REQUIRED.** Please **DO NOT SEND MEDICAL RECORDS**. A representative from Tough Enough to Help Cancer Fund will contact your medical provider, to verify diagnosis and needed travel. We will not ask for or accept medical records.
- **ASSISTANCE AGREEMENT** is assistance with household **expenses** and **travel** only. We cannot assist with medical bills, medical supplies, prescriptions or PAST expenses incurred.
- **Monies are not paid directly to the applicant.** Monies are paid to the company the bill is owed to, or are provided in pre-loaded VISA cards for travel.
- Assistance is granted every 12 months, as long as applicant is currently receiving treatment due to **active** cancer.
- Assistance must be used within 12 months of **application approval**.

Help for Health • Tough Enough
716 College View Dr. Suite B • Riverton, WY 82501
Phone • 307-856-1206 Fax • 307-856-6056

REQUEST FOR ASSISTANCE

Please print and complete the entire form

Applicant's Name: ____

Age: ______________ Race: ______________ Gender: ____________

Physical Address: ____

City: ________________________ Phone: ____________________

Are you a resident of Fremont County? ☐ Yes ☐ No

*Must provide certification of residency such as a utility bill.

Emergency Contact Information

Name: ________________________ Phone:____________________

Address: ______________________ Phone:____________________

City: ________________________ State: __________ Zip:________

Medical Information

Doctor Name: ____________________ Doctor Phone:________________

Diagnosis: ____

Describe assistance needed and how that assistance will affect you. (Use the back if more space is needed)

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Signature of Applicant: ________________________ Date: ____________

Signature of Witness: __________________________ Date: ____________

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Tough Enough to Help

Fremont County's non-profit assistance fund

Cancer Fund

AUTHORIZATION TO RELEASE INFORMATION

This form is used to release your protected health information as required by federal and state laws. Your authorization allows your doctor and hospital to release your protected health information to a person or organization that you choose. You can revoke this authorization at any time by submitting a request in writing to your doctor and hospital. Revoking this authorization will not affect any action taken prior to receipt of your written request.

Name: ____

Address: ____

Phone Number: __________________________________ Date of Birth: __________________

I (print your name) ____
authorize (print doctor's office name & address): ______________________________________

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to release my protected health information to Help for Health Tough Enough to Help Cancer Fund.

The information to be released consists of the diagnosis, schedule, and course of treatment in order to determine eligibility and the extent of support to be received through the Tough Enough to Help Cancer Fund.

This authorization will expire when I notify both the doctor and hospital listed above that I have revoked it.

By signing below, I authorize the release of my protected health information as described above.

Name: (please print) ____

Signature: ____ Date: _____________________

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ASSISTANCE AGREEMENT

This agreement is set forth by Help for Health Tough Enough to Help Cancer Fund, and is between the parties signed below. The Tough Enough to Help Cancer Fund is able to assist families with regular household bills, travel expenses, and other day-to-day expenditures. We cannot, however, provide relief for incurred medical expenses. Non-essential items or expenses will be paid at the discretion of the board members.

Date: ____

Family Representative: ____

Help for Health Representative: ____

Please Note: Failure to return receipts may result in the inability of the fund to offer any further assistance. If funds are misused, the Tough Enough to Help Cancer Fund will seek reimbursement legally if necessary.

For Office Use Only

Determination: ____________________________________ Date:______________________

Paid: ____ Date:______________________

Receipts Received: ________________________________ Date:______________________

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Tough Enough to Help *Cancer Fund*

Fremont County's non-profit assistance fund

REFERRING PROFESSIONAL AGENCY FORM

Your assistance request will not be considered without a professional referral

Applicant's Name: ____ Date: ____________________

Please describe the situation of the applicant and why assistance is needed. Please include information that could help us make a determination. Also, please include prescriptions for items such as assistive devices form medical doctor if applicable.

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Signature of Referring Professional: ____

Referring Agency: ____

Address: ____

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