PAT HEARN AND COLIN DE LAND CANCER FOUNDATION
FINANCIAL GRANT APPLICATION FORM

The Pat Hearn and Colin de Land Cancer Foundation is a Not-for Profit Corporation that provides financial grants to individuals in the visual arts community with cancer in the New York Metropolitan area. Our grants provide funds for medical services that improve the quality of life of individuals with cancer, including traditional and nontraditional medical care and hospice care that is not otherwise covered by insurance. Our grants are NOT for basic living expense such as rent, mortgages, utility payment or food. Grants are provided based upon demonstrated financial need.*

The personal and financial information portion of this form should be completed by the patient. In the event that the patient does not have capacity, it may be completed by a legal health care proxy.

The medical information portion should be completed by the physician caring for the patient. If you do not want your health care provider to see your personal and financial information, have her fill out the medical information portion first.

Basic Eligibility Criteria:
1. Applicant must be a member of the visual arts community.**
2. Applicant must have a definitive diagnosis of cancer.
3. Applicant must demonstrate financial need.*
4. Applicant must present a specific plan of how the money will be spent.

Personal Information

Last Name ________________________First Name __________________

Date: _________

Address: ________________________________

City/State/Zip: ______________________

Phone: Home _______________________Work: _________________________

Email:________________________________

Date of Birth: _____________________

Male ____ Female ____

Medical Information:
To Be Completed by your Doctor, Nurse or Social Worker Only:

Medical Information
Date of Diagnosis: ______________
Primary Cancer: ________________________________
Stage of Cancer: ________________
Is patient in active treatment? Yes ___ No ___
If No, is post treatment follow up needed? Yes ___ No ___
If Yes, please indicate type of follow up:
Yearly ___ Every Six Months ___ Other ____________
Physician's Name ____
Hospital/Clinic____
Address____
City/State/Zip: ________________________
Phone:________________Fax:______________
Signature of person completing medical section:
____
Print
Name/Title:____
Phone (if different than
above):____
Relationship to Person Applying for Help: Doctor ___ Nurse ___ Social Worker
___

In what way are you a member of the visual arts community?______________
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Health Insurance Information
Do you have health insurance? Yes_____ No ____

If yes, please indicate type of insurance: (check all that apply)
Medicaid ___ Private Insurance ___ Medicare Only ___
Medicare plus Medicaid ___ VA Program____ Medicare plus other
supplemental coverage____ Other _______________________________________

Are prescription drugs covered? Yes ___ No ___

Financial Information

Are you currently employed Yes ___ No ___
Number in household_____________
Income Source (Please check all that apply):
Social Security (retirement) ___ Alimony ___ Salary ___
Pension ____ Public Assistance ___ Short Term Disability ___
In-Kind (room and board) ___ Child Support ___ Family/Friends provide support ___ SSD (Disability) ___ Unemployment ___ SSI ___ Other ________

Gross Income:
Salary: ________________
Interest/Dividends/Royalties: ________________
Income from art: ______________
Alimony/Child Support: _____________
Rental Income: ____________
Public Assistance: _______________
Unemployment: _____________
Veterans Benefits: __________
Social Security: __________
SSI: _____________
Pension: __________
Other Benefits: __________
Other Income: _______

Total Gross Income: ________

Liquid Assets:
Checking:__________________
Savings/CD:___________________
Money Market: _____________
Stocks:____________________
Bonds: ____________________

Total Liquid Assets: ______________

A copy of your last year's income tax form must accompany this application. If your financial situation is significantly different from that which appears on your last year's income tax form, please provide a brief explanation.

Please provide a detailed budget indicating how you will spend the money provided, if approved. Please be aware that our grants are not for basic living expenses such as rent, mortgages, utility payments and food. Please also note that our grants are not for medical care that is reimbursable through insurance. Applicants will be asked to submit receipts for the care provided utilizing grant funds. Each grant application form is limited to $5,000.00
[Example of budget:

Hospice nurses aide care utilizing XXX Nursing Agency: 5 hours per day @ $40 per hour for 10 days: $2,000.00
Reike massage with XXX Massage Agency: 10 sessions @ $80 per session: $800.00
Psychological Counseling with XXXX: 1 session per week for 10 weeks @ $90 per session: $900.00
Total requested: $3,700.00]

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I hereby attest that the information provided above is accurate to the best of my knowledge.

Signature____
If form is being filled out by the applicant's legal health care proxy please provide name and relationship to applicant:
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Thank you. Funds are limited and based on availability. All information is strictly confidential. THE FOUNDATION RESERVES THE RIGHT TO ACCEPT OR REJECT ANY APPLICATION IN ITS SOLE AND ABSOLUTE DISCRETION.

* The Pat Hearn and Colin de Land Cancer Foundation uses financial eligibility criteria similar to that utilized by the New York State Department of Health for its AIDS Drug Assistance Program. This criteria is income less than $44,000 per year for a household of one, $59,200 for two and $74,400 for three and liquid assets less than $25,000.

Please send (mail or messenger) completed Application to: Sam Grubman
70 East 10th Street, New York, NY 10003. If you have questions regarding completion of the application contact sgrubman@phcdl.org

**Please attach a copy of your resume and/or other materials which evidence that you are a member of the visual arts community.