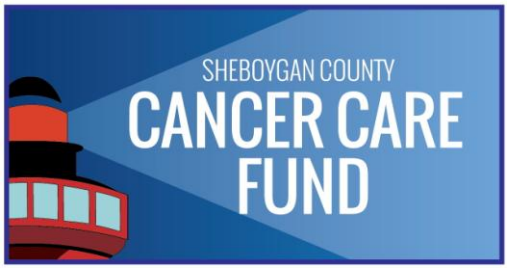

The Sheboygan County Cancer Care Fund (SCCCF) is dedicated to improving the health, well-being, and quality of life for individuals and families of Sheboygan County who have been diagnosed with cancer or a disease of the blood.

1621 N. Taylor Drive, Suite 100
Sheboygan, Wisconsin 53081
920-457-2223 ● www.scccf.org

Request for Funding

The SCCCF is supported entirely by public contributions. It is important that these limited funds be available for patients who are experiencing the greatest financial need. Listed below are some questions to consider before completing this application or requesting funding:

1. What impact has the diagnosis had on your current income or financial situation?
2. What unusual out-of-pocket expenses do you have as a result of the diagnosis?
3. What other financial resources do you have access to that may assist with these expenses?

If you believe you are in financial need at this time, please review the following guidelines:

- SCCCF offers limited short-term financial assistance to individuals who have been diagnosed with cancer or a disease of the blood and who reside in or receive their primary cancer treatment in Sheboygan County.
- Funding approvals and limits are based upon available funding.
- SCCCF does NOT pay medical expenses or bills at cancer clinics or hospitals located in Sheboygan County.
- All requests require a complete and accurate application (incomplete applications may delay processing).
- Please allow up to ten business days for processing (you will receive notification upon approval/denial).
- Please submit your application and contact us accordingly:

Primary Cancer Treatment Facility:	Contact:	Send Application To:
Matthews Oncology Associates **Sheboygan Cancer & Blood Specialists**	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081
Aurora / Vince Lombardi Cancer Clinic	**Stephanie Struve, CSW** 920-457-4461	1222 N. 23rd St. Sheboygan, WI 53081
All Other Locations (Will need to provide written confirmation of diagnosis)	**Tim E. Renzelmann** 920-458-7433	1621 N. Taylor Drive Sheboygan, WI 53081

Section 1: ***Person (cancer patient/survivor) in need of or requesting assistance:***

_____ _____
Last Name, First Name, Middle Initial — Date of Birth

_____ _____
Address — Phone Number

_____ _____
City, State, Zip — Social Security Number

_____ _____
Diagnosis/Disease/Condition — Date of Diagnosis

_____ _____
Physician — Phone Number

Section 2: ***I (above named individual) attest the following to be true:***

I have been medically diagnosed with a cancer or blood disease. ..... ☐ **Yes** ☐ **No**
I currently reside in Sheboygan County..... ☐ **Yes** ☐ **No**
I receive my primary oncology/hematology care in Sheboygan County..... ☐ **Yes** ☐ **No**
I am experiencing financial hardship as a result of my diagnosis and/or related treatment..... ☐ **Yes** ☐ **No**
I attest that expenses represented herein represent actual "out of pocket" expenses..... ☐ **Yes** ☐ **No**
I have pursued additional personal/community resources..... ☐ **Yes** ☐ **No**
If "Yes" please describe below:

Section 3: ***Describe your current financial situation and need for assistance (use additional paper if necessary):***

_____

_____

_____

_____

_____

_____

Section 4: ***Specific Request Information.*** *Please include all appropriate documentation (i.e., copies of official invoices, receipts or outstanding bills that include name of provider, address, and balance). Copies of paid receipts are necessary in order for us to reimburse expenses already paid by an individual. In addition to appropriate documentation, provide detailed information below:*

Request 1	Amount Requested: $_____.____	Purpose of Funds (please explain):
Check Payable To:		
Mailing Address:		**For SCCCF Use Only: Approved ☐ Yes ☐ No** **Date: ____/____/____** **Amount Approved: $_____.____** **Authorizing Signature(s):**
City, Stage, Zip		

Request 2	Amount Requested: $_____.____	Purpose of Funds (please explain):
Check Payable To:		
Mailing Address:		**For SCCCF Use Only: Approved ☐ Yes ☐ No** **Date: ____/____/____** **Amount Approved: $_____.____** **Authorizing Signature(s):**
City, Stage, Zip		

Request 3	Amount Requested: $_____.____	Purpose of Funds (please explain):
Check Payable To:		
Mailing Address:		**For SCCCF Use Only: Approved ☐ Yes ☐ No** **Date: ____/____/____** **Amount Approved: $_____.____** **Authorizing Signature(s):**
City, Stage, Zip		

Section 8: ***Agreement (to be signed by the individual listed on Section 1 of this application)***

I certify that all information that in this written application is correct and true to the best of my knowledge. I agree that all funds received will be used for the purpose stated herein. I understand that I will be liable for any funds that are incorrectly used or that were acquired through intentional misrepresentation. I understand that submission of this application does not constitute approval of funding and I remain responsible for these expenses until approval determination has been made. I also understand that approval of funding may be contingent upon my financial need, availability of funds and the rules, policies and discretion of SCCCF.

_____ _____

Signature of individual listed on Section1 (required-unless waived by SCCCF) Date

_____ _____ _____

Name of Person Completing Application (if other than individual listed on Section 1) Relationship Signature of Person Completing Application