Can't Hurt Steel Community Foundation

The CHS Community Foundation is a component fund of the Community Foundation of Orange and Sullivan County; and, it is a community based organization whose mission is to help families experiencing catastrophic loss or illness as well as to promote leadership, wellness, and community development.

The CHS Community Foundation has a limited amount of discretionary funds that can be used to award grants to individuals battling catastrophic illnesses (such as aggressive cancers) or catastrophic loss (such as loss of home due to fire). These funds are intended to assist with medical and living expenses incurred while trying to recover from catastrophic illness or loss, and grants are being made for such purpose.

Eligibility Requirements:

- You are a current patient, undergoing treatment for an aggressive cancer or catastrophic illness; or
- You recently experienced a catastrophic loss (such as losing your home to a fire).
- You reside in Sullivan County or are an individual residing elsewhere who has a sufficient connection to the CHS Community Foundation (as determined by the CHS Grant Committee).

General Information:

The CHS Community Foundation will issue grants in an amount up to **$500**. Grants are pending funds available on a yearly basis.

Grant Application Process for Patient to Follow:

Step 1: Determine eligibility & Complete the Application (FORM A)

Step 2: Complete the Physician Medical Release Form (FORM B)

Step 3: Complete the Patient Medical Release Forms (FORM C)

Step 4: Copy of photo-ID

Step 5: Return all original forms, and a copy of photo-ID to:

Can't Hurt Steel Community Foundation P.O. Box 333 Eldred, NY 12732

A representative of the CHS Community Foundation will follow up with you if a grant is considered on your behalf. The representative may ask you to provide receipts for expenses and/or copies of bills to be paid, or for reimbursement. Medical/living expenses will be paid directly to the billing entity, and on only very rare occasions, to the grantee directly.

MAIL ORIGINAL FORM TO: Can't Hurt Steel Community Foundation P.O. Box 333 Eldred, NY 12732

Can't Hurt Steel Community Foundation

FORM A

PATIENT NAME_____

PHONE NUMBER_____

EMAIL_____

DATE OF BIRTH_____

MAILING ADDRESS_____

EMERGENCY CONTACT NAME/TELEPHONE NUMBER_____

DIAGNOSIS AND TREATMENT PLAN_____

NAME & TELEPHONE NUMBER OF TREATING PHYSICIAN_____

_____

GRANT AMOUNT REQUESTED?_____

HOW WILL THIS GRANT BE SPENT?_____

WHO REFERRED YOU TO US?_____

I HEREBY AGREE THAT THIS INFORMATION CAN BE SHARED WITH THE CAN'T HURT STEEL COMMUNITY FOUNDATION. I ALSO AGREE THAT THE CAN'T HURT STEEL COMMUNITY FOUNDATION MAY SHARE INFORMATION ABOUT THIS GRANT IN ORDER TO INCREASE SUPPORT AND OBTAIN CONTRIBUTIONS, SO THAT OTHERS MAY BE HELPED IN THE FUTURE.

_____**I GIVE PERMISSION** TO CHS COMMUNITY FOUNDATION TO USE MY NAME, PHOTO AND INFORMATION

_____**I DO NOT GIVE PERMISSION** TO CHS COMMUNITY FOUNDATION TO USE MY NAME, PHOTO AND INFORMATION

SIGNATURE:_____ **DATE:** _____

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FORM B

MEDICAL RELEASE OF INFORMATION TO: CAN'T HURT STEEL COMMUNITY FOUNDATION

To be completed by treating physician

1. Name of Patient: _____Patient's date of birth: ____/____/___

2. Patient's diagnosis: (you may attach information on a separate sheet with letterhead)

_____

_____

_____

3. Date of diagnosis: _____

4. Current treatment plan:_____

5. When did you begin treating this patient? _____

6. Expected duration of treatment:_____

Physician Name: _____

Physician Telephone #_____

Physician Address_____

I see the patient: Daily* Weekly *Monthly *Other (specify) _____

Signature of Physician _____ **Date:** _____

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FORM C

PRIVACY STATEMENT AND MEDICAL RECORDS RELEASE

To be completed by Patient

PRIVACY STATEMENT:

The privacy of your personal and medical information is important to the Can't Hurt Steel Community Foundation and we are committed to protecting your information. In order to process your grant application, we may need to share limited personal information in the following ways:

- For coordination of payment of services funded;
- To verify information from your doctor and/or health practitioner;
- With board members of the Can't Hurt Steel Community Foundation to make decisions for your funding.

I authorize my treating physician, identified in Form A, to release the information requested in Form B to the Can't Hurt Steel Community Foundation. I also authorize the physician to speak to a representative from the Can't Hurt Steel Community Foundation to verify information, if needed, for a grant I am requesting.

(Please refer to our Privacy Statement above)

Signature of Patient:_____ Date: _____

PLEASE PRINT:

Name of Patient: _____

Address of Patient: _____

Phone: _____Email:_____

MAIL ORIGINAL FORM TO: Can't Hurt Steel Community Foundation P.O. Box 333 Eldred, NY 12732