Qualifications for Approval

1. For an applicant to be considered for a grant **all** sections of the "Patient Grant Application" **must** be filled out properly. An unfinished application will not be accepted.
2. The application must be reviewed, signed and submitted by a hospital/cancer network social worker, navigator or qualified professional. Applications signed by any other individual will not be accepted.
3. On the "Patient Grant Application" the section entitled, "Medical Information" must be filled out by the applicant's certified medical professional. The doctor's signature certifies that the applicant currently has cancer.
4. The applicant must currently be in cancer treatment.
5. The applicant must meet the financial guidelines of the 2020 Federal Poverty Guidelines. Their income is based on the number of people in the household and cannot exceed the 250% Income column (highlighted) of the chart.
6. The applicant must live within our geographic boundaries including the following counties in Pennsylvania: Berks and Chester Counties.

Qualifications are effective February 22, 2020

Persons in Household	48 Contiguous States and D.C. Poverty Guidelines (Annual)							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$12,760	$16,971	$17,609	$19,140	$25,520	$31,900	$38,280	$51,040
2	$17,240	$22,929	$23,791	$25,860	$34,480	$43,100	$51,720	$68,960
3	$21,720	$28,888	$29,974	$32,580	$43,440	$54,300	$65,160	$86,880
4	$26,200	$34,846	$36,156	$39,300	$52,400	$65,500	$78,600	$104,800
5	$30,680	$40,804	$42,338	$46,020	$61,360	$76,700	$92,040	$122,720
6	$35,160	$46,763	$48,521	$52,740	$70,320	$87,900	$105,480	$140,640
7	$39,640	$52,721	$54,703	$59,460	$79,280	$99,100	$118,920	$158,560
8	$44,120	$58,680	$60,886	$66,180	$88,240	$110,300	$132,360	$176,480
Add $4,480 for each person over 8								

How Does This Work

Procedure for Grant Application and Approval

1. Applicant (or family/friend) fills out grant application and has the applicant's medical professional fill out the Medical Information section. See #2 under qualifications.
2. Applicant or medical professional mails grant application form to OneRunTogether at 135 Schoolhouse Lane Coatesville, Pa 19320. Applications may also be E-mailed to vmurphy@oneruntogether.org.
3. At this point, the applicant should start collecting a few bills that total around $700.00* and have them ready to mail to OneRunTogether Inc. if they are approved for a grant.
4. OneRunTogether Inc CEO, Vernon Murphy, reviews the application and contacts the medical professional or applicant only if there are any questions about information provided or left unanswered.
5. Vernon Murphy submits the application to OneRunTogether's Board of Directors.
6. Within a couple weeks the Board Members review and make their decision approving or denying the grant.
7. Vernon Murphy Calls applicant with approval or denial status of the grant. If approved, Vernon will set up a date to meet the applicant to give assistance.

*** Grant amount is at the discretion of the Board of Directors and is based on need and available funds. Checks for the applicant's bills that are due are only written to the collection company. No funds will be given directly to the applicant. The applicant is responsible for mailing the bill along with any remaining payment due to the collection agency.**

OneRunTogether Inc., Grant Application for Cancer Patient Assistance

APPLICANT (PATIENT) INFORMATION (please print clearly)

First Name: _____ Last Name:_____ Today's Date: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____
Phone Number: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____ Date of Birth: _____

If Applicant is a minor (under 18), Name of Parent and/or Guardian: _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widow(er)

OneRunTogether Inc. does not discriminate on the grounds of race, gender, or marital status.

The Applicant is: ☐ A Citizen of the U.S. ☐ Not a Citizen of the U.S.

Ethnicity: ☐ Caucasian ☐ African American ☐ Latino ☐ Asian ☐ Other_____

MEDICAL INFORMATION PLEASE COMPLETE ALL FIELDS (This Section Must Be Completed By Doctor, Nurse, Social Worker or Hospital ACS Patient Navigator Only)

Date of Definite Cancer Diagnosis: _____ Primary Cancer: _____ Stage: _____

☐ New Diagnosis ☐ Recurrence Is Applicant in Active Treatment: ☐ Yes ☐ No

Current Treatment: ☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative Care ☐ Bone Marrow/Stem Cell Transplant

If **NOT** in active treatment, indicate frequency of follow up: ☐ Yearly ☐ Every Six Months ☐ Other_____

HEALTH CARE PROFESSIONAL INFORMATION (please print clearly)

Medical Physician: _____ Hospital/Clinic: _____
Address: _____ City :_____ State: _____ Zip Code:_____
Phone Number: ( ) _____ Fax Number ( ) _____ Email Address: _____

As a medical professional, I hereby verify that the above information is true and correct to the best of my knowledge and belief.

Signature of Medical Professional: _____ Date: _____

NAME AND TITLE OF PERSON COMPLETING THIS FORM (all information must be verified and signed by a medical professional)

Name: _____ Phone Number: ( ) _____ Email Address: _____

☐ Physician ☐ Nurse ☐ Social Worker ☐ ACS Hospital Navigator ☐ Other: _____

OneRunTogether Inc., Grant Application for Cancer Patient Assistance

HEALTH INSURANCE INFORMATION

Does the Applicant have Health Insurance: ☐ Yes ☐ No

If Yes, please indicate type of insurance (check all that apply)

☐ Private Insurance ☐ Medicaid ☐ Medicare Plus ☐ Medigap ☐ Charity Care ☐ VA Program ☐ Other: _____

Are prescription drugs covered by Applicant's Health Insurance Plan? ☐ Yes ☐ No

HOUSEHOLD FINANCIAL INFORMATION

Is Applicant currently employed: ☐ Yes ☐ No Is the Applicant's Spouse/Partner currently employed: ☐ Yes ☐ No

Number of people in household (including Applicant): _____ How many children (ages 17 and under) depend on your income: _____

How old are the children that depend on your income: _____

FAMILY INCOME SOURCES: (please give monthly amounts for all that apply)

Social Security $_____ Salary $_____ Pension $_____ Unemployment $_____ Retirement $_____ Public Assistance $_____

SSD (Disability) $_____ SSI $_____ Family/Friends $_____ Short Term Disability $_____ Other $_____

Applicant's Total Annual Income: _____ Spouse/Partner of Applicant's total income: _____

Family Assets (provide total amount in all accounts that the Applicant and their immediate family members own):

Checking $_____ Money Market $_____Savings $_____ CD $_____ IRA/403b/401k $_____

Stocks & Bonds $_____ Inheritance & When it was given to you $_____ Trust Fund(s) $_____ Other $_____

Total Family Assets (add all family assets together) $_____ ***If more space is needed please attach a separate sheet with all details**

How much credit card debt do you have: $_____ How much is your monthly mortgage or rent payment: $ _____

Do you have family that is able to assist you financially? Yes or No (circle one)

FINANCIAL ASSISTANCE NEEDED (please fill in estimated amount of assistance needed for each category)

I need assistance with the following cancer-related expenses:

Transportation $_____ Child Care $_____ Home Care $_____ Pain Medication $_____ Co-Pays $_____

Lymphedema Supplies $_____ Insurance Bills $_____ Other $_____

I hereby verify that all of the information in this application is true and correct to the best of my knowledge and belief.

Applicant Signature:_____ Date: _____

Please be advised that our funds are limited and based on availability. All applicants must meet OneRunTogether Inc's eligibility requirements. Our grants **are** for medical bills and/or insurance co-payments and living expenses such as rent, mortgages, utility payments, childcare, etc. OneRunTogether Board of Directors will determine the function and final use of this grant and a check will be written directly to the collection agency or bill issuer to whom the money is due. **If any information found to be purposely misrepresented the applicant will be permanently denied assistance and any assistance given will be owed back to OneRunTogether Inc.**

Please mail this application to OneRunTogether Inc, 135 Schoolhouse Lane, Coatesville, Pa 19320 or E-mail it to Vernon Murphy, Executive Director and Founder, at Vmurphy@OneRunTogether.org.

All information is strictly confidential and is for OneRunTogether Inc., use only. **INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED 2/22/2020**