SCARE AWAY CANCER ELIGIBILITY REQUIREMENTS

1. A cancer patient with a life-threatening medical condition is potentially eligible for a gift of financial assistance which will facilitate quality of life for the patient and their family.

2. A gift must directly benefit the patient and his/her family by assisting with medical expenses, daily living, and travel expenses as they need to keep their daily life as normal as possible.

3. Gift requests must directly benefit and enrich the life of the cancer-stricken patient and family.

4. Applicants must reside in the Omaha-Lincoln-Council Bluffs area.

5. There is no income limit, but we want to help those in the greatest of need that are unable to do so on their own. We look at each application individually. We look at the taxable income, take into consideration how many people live in the household, and geographic location. Higher consideration may be given to a patient where the impact of the disease affects children.

6. Application must be completed in its entirety in order to be considered.

7. Return the completed application to:

   Scare Away Cancer
   Attn: Paula Ebert
   14558 Portal Cir
   Omaha NE 68138

APPLICATION

APPLICANT INFORMATION		
Name of Cancer Patient:		Date:
Date of birth:		Phone:
Current address:		
City:	State:	ZIP Code:
Insurance Coverage:		

PRIMARY CANCER DIAGNOSIS		
Primary Cancer Diagnosis:		
Current Stage:	New Diagnosis:	Recurrence:
Is patient in active treatment?		
Please indicate type of treatment(s) received in past twelve months (check all that apply): ☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Palliative Care ☐ Bone Marrow/Stem Cell Transplant		

FAMILY INFORMATION
Name parent(s)/guardian(s) or spouse:
Email Address:
Names/Ages/Relationships of those living with applicant:

FINANCIAL INFORMATION		
Please list all current employer(s) of applicant and/or parent(s)/guardian(s).		
Current employer (applicant or parent/guardian(s)):		
Employer(s) address:		How long?
Phone:	Fax:	
City:	State:	ZIP Code:
Position:	Hourly Salary *(Please circle)*	Annual Salary:

Current employer (applicant or parent/guardian(s)):		
Employer(s) address:		How long?
Phone:	Fax:	
City:	State:	ZIP Code:
Position:	Hourly Salary *(Please circle)*	Annual Salary:
Total Annual Household Income (please include all salary, alimony, child support, etc.):		
Own Rent *(Please circle)*	Monthly payment or rent:	How long?
List **All Monthly** Expenses, e.g., food, auto, gas, child care, utilities, mobile phone, insurance, etc. (use additional pages if necessary):		
List **ALL Medical-Related Expenses**, e.g., travel costs, unexpected expenses (use additional pages if necessary):		

NAME/RELATIONSHIP OF PERSON COMPLETING APPLICATION (IF DIFFERENT FROM APPLICANT)		
Name	Address	Phone
Relationship to Applicant:		Email:
Signature of applicant/requestor:		Date:
Printed Name of Signer:		

HOW DID YOU HEAR ABOUT SCARE AWAY CANCER?

PLEASE ELABORATE ON YOUR INDIVIDUAL SITUATION OF NEED (TELL US YOUR STORY). PLEASE USE ADDITIONAL SPACE AND/OR INCLUDE PHOTOS IF YOU SO DESIRE.

No patient information will be shared with anyone outside of Scare Away Cancer without prior approval from the patient or patient's family's written consent.