ONE COMMUNITY
ONE FAMILY

Our mission is to provide support at diagnosis to cancer patients in the Skagit Valley Community. We believe most people are not fully prepared for the overwhelming emotional and physical changes, as well as financial hardships, during this time. Our volunteers are dedicated to the long-term success of this grant program through ongoing donations and fundraising efforts.

GRANT APPLICATION

(Subject to Available Funds)

****REQUIRED INFORMATION****

(Completion of all line items within the "Required Information" area is necessary for you to be considered for grant from OCOF.)

APPLICANT NAME: _____
MAILING ADDRESS: _____
CITY _____STATE/ZIP_____
PHONE NUMBER: _____ EMAIL _____
TYPE OF CANCER (WITH STAGE, IF KNOWN) CURRENTLY BEING TREATED: _____
_____
DATE DIAGNOSED: _____
DOES YOUR TREATMENT PLAN INCLUDE (circle all that apply):
SURGERY CHEMOTHERAPY RADIATION OTHER _____

NAME OF HOSPITAL/CARE CENTER WHERE MEDICAL CARE IS BEING RECEIVED:
_____
NAME OF ATTENDING PHYSICIAN (PLEASE PRINT):
_____
SIGNATURE OF ATTENDING PHYSICIAN:
_____ DATE: _____
ATTENDING PHYSICIAN PHONE NUMBER: _____
MAY WE CALL THIS NUMBER TO VERIFY? YES/NO

ARE YOU EMPLOYED? YES/NO if yes, circle one: FULL/PART TIME
NAME OF EMPLOYER? _____

PRIMARY CAREGIVER NAME (IF APPLICABLE)? _____
IF CAREGIVER IS YOUR SPOUSE/PARTNER, WILL THEY BE TAKING UNPAID TIME OFF WORK? YES/NO
IF YES, WHERE IS THE CAREGIVER EMPLOYED? _____
DO YOU HAVE DEPENDENTS? YES/NO
IF YES, HOW MANY? _____ DEPENDENT AGES: _____

HOW WILL THIS GRANT ASSIST YOU:
_____
_____
_____
_____

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HAVE YOU PREVIOUSLY APPLIED FOR A GRANT FROM OCOF: YES/NO
IF YES, HOW LONG AGO? _____
HAVE YOU PREVIOUSLY RECEIVED A GRANT FROM OCOF: YES/NO
IF YES, HOW LONG AGO? _____
HOW DID YOU HEAR ABOUT THIS GRANT?
(List name, address, phone # & relationship of the person who referred you.)

_____

_____

_____

By signing below, you are stating that all of the above information is accurate.

APPLICANT'S SIGNATURE *(If 18 years of age or older):*

_____**DATE:_____**

PARENT OR LEGAL GUARDIAN'S PRINTED NAME & SIGNATURE IS REQUIRED *(If applicant is under the age of 18):*

_____**DATE:_____**

NOTE: To qualify for a One Community One Family Grant, the applicant must currently be receiving medical care for cancer with the physician listed above. These grants are prioritized and intended for residents of Skagit Valley, WA.

ADDITIONAL COMMENTS – TELL US MORE ABOUT YOUR SITUATION (OPTIONAL):

_____

_____

_____

_____

One Community One Family does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. These activities include, but are not limited to, employment selection of volunteers and vendors, and the provision of grants and services.

Thank you for taking the time to apply for our grant. All applications will be reviewed on a monthly basis and applicant will be notified within 7-10 days of decision. Applications will be held on file for 90 days.
All information will be kept confidential.

RETURN SIGNED APPLICATION TO:
contact@skagitocof.org
or
One Community One Family
P.O. Box 1163
Burlington WA 98233

For Office Use Only
Case #: _____ Date Received: _____
Amount Approved: _____ Approved By:_____
Check#:_____

Skagit Valley Resident/Applicant Is From (√):
___Burlington ___Mount Vernon ___Sedro Woolley ___La Conner
___Anacortes ___Other: _____
Revised 9/9/20

One Community One Family Medical Authorization and Release

PHYSICIAN:
ADDRESS:

THE UNDERSIGNED, for legal purposes pursuant to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Section 164.508 of the final Privacy Rule, RCW 70.02, and applicable regulations issued thereunder, authorizes the release and disclosure by any insurance company, health care provider, clinic, hospital, physician, nurse, pharmacist, or a duly authorized representative of the same, of all protected health care information, including medical records and information concerning all aspects of care or treatment rendered (***except*** sensitive health care information protected by 42 CFR, Part II (substance use disorder) or RCW 70.24 (control and treatment of sexually transmitted disease)) to any representative of **One Community One Family, a Washington non-profit corporation, PO BOX 1163, Burlington, WA 98233**.

The information released will be used to enable One Community One Family to determine eligibility for a charitable grant; and to further this purpose and in fulfillment of such grant application, the undersigned authorizes his/her primary physician and/or oncologist to provide, upon reasonable request, One Community One Family additional information relating to the undersigned's medical eligibility and medical needs.

The undersigned, individually, and on behalf of his/her heirs, representatives and assigns, shall forever release, indemnify, and hold harmless One Community One Family for any and all claims, demands or causes of action for any injury or damages arising out of any disclosures of protected medical information pursuant to the grant application process and pursuant to this Medical Authorization and Release.

In compliance with HIPAA and Section 164.508 of the final Privacy Rule, the undersigned acknowledges:

- I do not have to sign this authorization and release in order to obtain health care benefits (treatment, payment or enrollment).
- I may revoke this authorization in writing at any time, and such revocation shall be effective as of the date such written notice is received by the above-named provider or One Community One Family.
- I understand and acknowledge that if the person or entity that receives the information described above is not a healthcare provider or health plan covered by federal privacy regulations (such as One Community One Family), that such information will no longer be protected by regulations and privacy rules of 45 CFR § 164 and could be disclosed or re-disclosed by such recipient.
- A photostatic, digital or electronic copy of this document shall be as valid as the original.
- This authorization expires ninety (90) days from the date signed.

Dated this _____ day of _____

Signed: _____
Written Name: _____
Date of Birth: _____
SSN: _____