

ORION GRANT FUND



GRANT GUIDELINES

The O'Callaghan Resource Integrated Oncology Network (ORION) Cancer Grant Fund was established to provide financial assistance to cancer patients for basic living necessities and is an adult funding program of Nevada Childhood Cancer Foundation (NVCCF - a nonprofit, 501 (c) 3 organization.)

Eligibility Criteria:

- Patients, at least 18 years of age, who are currently receiving medical treatment for cancer in Southern Nevada. **Oncologist's letter must include present treatment type such as chemotherapy, etc.**
- Those who demonstrate diagnosis related financial hardship
- Eligible applicants may receive funding NOT to exceed \$1,500 in a 12-month period for rent, mortgage, utilities, car payments, and insurance co-pays

Medical expenses are NOT paid (except for the initial screening mammogram for uninsured individuals). If approved, funds are paid directly to the addresses provided on the submitted bills.

Application Process: Applications for assistance may be approved ONE TIME only within a 12-month period. Completing a grant application does **NOT** guarantee funding. Application are available at www.nvccf.org and may be submitted attention to ORION Cancer Foundation by:

- **Mail:** c/o NVCCF, 3711 E. Sunset Rd., Las Vegas, NV 89120
- **Email:** info@nvccf.org
- **Fax:** 702.735.8431

REQUIRED DOCUMENTATION - Include the following documentation with your application:

- Letter on ONCOLOGISTS's letterhead **verifying current cancer diagnosis & present treatment type.**
- Grant Request Personal Data (Page 2)
- Grant Request Worksheet (Page 3)
- All back-up documentation on Grant Request Worksheet (Page 3)
- Grant request Signature Page (Page 4)

Applications are NOT considered COMPLETE without ALL required documentation. Incomplete applications will not be reviewed. APPROVED FUNDS ARE MANAGED AND APPROVED BY A GOVERNING GRANT DONOR BOARD. REASONS FOR DECLINES WILL NOT BE PROVIDED.

NVCCF STAFF MEMBERS DO NOT HAVE ACCESS TO ANY ORION GRANT INFORMATION. All applicants will receive a message of approval OR denial within 60 days of receipt by ORION.

**ORION Cancer Foundation
GRANT REQUEST WORKSHEET**

**A COPY of all documentation required for funding consideration.
Applications will be **REJECTED** without review if back-up is not
included.**

Provided	List INCOME – INCLUDE COPIES	Amount
<input type="checkbox"/>	Your total gross monthly salary (pay stubs or tax return)	\$ _____
<input type="checkbox"/>	Your spouse/partners gross monthly salary (paystub or tax return)	\$ _____
<input type="checkbox"/>	Disability	\$ _____
<input type="checkbox"/>	Social Security	\$ _____
<input type="checkbox"/>	Retirement/Pension/Death Benefit	\$ _____
<input type="checkbox"/>	Child/Spousal Support	\$ _____
<input type="checkbox"/>	Food Stamps	\$ _____
<input type="checkbox"/>	Other Income- Please explain	\$ _____
	Total Gross Monthly Income	\$ _____

	List AVERAGE MONTHLY EXPENSE – INCLUDE COPIES	Amount
<input type="checkbox"/>	Rent or Mortgage (mortgage statement/lease agreement)	\$ _____
<input type="checkbox"/>	Utilities	\$ _____
<input type="checkbox"/>	Power	\$ _____
<input type="checkbox"/>	Gas	\$ _____
<input type="checkbox"/>	Water	\$ _____
<input type="checkbox"/>	Trash	\$ _____
<input type="checkbox"/>	Child Support (court order or paystub)	\$ _____
<input type="checkbox"/>	Car Payment	\$ _____
<input type="checkbox"/>	Car Insurance	\$ _____
<input type="checkbox"/>	Health Insurance/COBRA/Co-Pays	\$ _____
<input type="checkbox"/>	Fuel (Average NO BACK-UP required)	\$ _____
<input type="checkbox"/>	Groceries (Average NO BACK-UP required)	\$ _____
<input type="checkbox"/>	Medical Bill deductibles/remaining balance due	\$ _____
<input type="checkbox"/>	Other Expenses- Please explain	\$ _____
	Total-Average Monthly Expenses	\$ _____

Please list the requested financial assistance below individually.

1. _____ \$ _____
2. _____ \$ _____
3. _____ \$ _____

Total Financial Assistance Requested \$ _____

ORION Cancer Foundation

GRANT REQUEST SIGNATURE PAGE

Please initial, signature, and print where applicable below:

I understand that completing and applying does NOT guarantee funding: _____
Initial

I understand that my application, to be considered for funding, must include all required documents: _____
Initial

I certify that the information provided on this application is true and accurate: _____
Initial

I release the ORION Foundation, Nevada Childhood Cancer Foundation, and all related subsidiaries of all liabilities or claims arising out of the assistance of services provided to me or my family. I authorize the ORION Foundation to obtain, from the individuals, businesses, organizations, agencies, or entities listed in this application, whatever information is necessary about my case that might be helpful for assessing my application.

PRINT NAME: Applicant or Parent/Legal Guardian Date

SIGNATURE: Applicant or Parent/Legal Guardian Date

How did you hear about the ORION Cancer Foundation? _____

APPROVED FUNDS ARE MANAGED AND APPROVED BY A GOVERNING GRANT DONOR BOARD. IF REQUESTS ARE DECLINED, APPLICANTS ARE FREE TO APPLY AGAIN BUT AS IN ALL GRANT AWARDS OR DECLINES, REASONS FOR DECLINES WILL NOT BE PROVIDED. NVCCF STAFF MEMBERS DO NOT HAVE ACCESS TO ANY ORION GRANT INFORMATION. INCOMPLETE GRANTS WILL NOT BE REVIEWED.

FOR ORION OFFICE USE ONLY: Date Received: _____

Date Reviewed: _____ Date Approved or Denied (circle): _____ Grant Amount: _____