Healthy Acadia
Building vibrant communities

CBF Christine B. Foundation

MCF Maine Cancer Foundation
CHALLENGE CANCER 2020

Beth C. Wright
Cancer Resource Center

The Colorectal Cancer Screening Support Fund (CCSSF) exists to help in cases where the cost of screening or transportation to screening, or other barriers prevent access to screening and when a ONE-TIME grant of LESS THAN $1,000 will ensure access to needed screening. Grants must be for a SPECIFIC NEED, paid directly to a vendor or service provider, and must be sufficient to meet the funding requirements of the specified need.

Date of request:	Date funds needed by:
Name of applicant:	Date of birth:
Address:	
City/Town:	Zip Code:
Telephone:	Email Address:

Amount requested: _____ (max: $1,000) to meet the following need(s):

☐ Screening (FIT tests) ☐ Screening (Cologuard) ☐ Transportation

☐ Childcare/Elder Parent Care ☐ Other

Please provide specific details on the screening test and/or support needed to access screening and how this financial support will help you (use additional pages if needed).

How do you pay for health care (select all that apply):*

___ No Insurance
___ MaineCare (Medicaid)
___ Health Insurance (e.g. private insurance)
___ Medicare
___ Veterans Administration
___ Indian Health Services
___ Other: _____

**The information you provide is only used to determine grant eligibility and will not be shared with anyone outside of the CCSSF.*

Service providers/vendors are paid on behalf of the applicant. Grants are not given directly to applicant.

Please contact the service provider/vendor who will provide this service to request a written proposal or estimate of the cost of service and obtain permission for a representative of CCSSF to speak directly to this person on your behalf.

You must include the written proposal or estimate provided by the vendor or service provider with this completed application.

Please initial the line below and provide the service provider/vendor's contact information.

_____ Applicant's initials verifying that a CCSSF representative has permission to speak with the chosen service provider/vendor and referring organization (if applicable).

Service provider / vendor name:	
Service provider address	Phone:
Person completing form:	Phone:
Relationship to applicant:	
Referring organization / agency (if applicable):	
Referring organization / agency contact person:	Phone:
Are the applicant and referring organization (if applicable) willing to remain in contact with the CCSSF to see how things worked out? ☐ Yes ☐ No	
Signature of applicant (verifying accuracy of the information contained in this application):	