**Cancer Care Specialists of Illinois Foundation**

The CCSI Foundation, an Illinois Not for Profit Corporation, was formed with the mission of providing compassionate support to individuals battling cancer and/or a blood disorder by alleviating financial burdens. We are dedicated to empowering patients and their families by offering financial assistance, resources, and guidance, helping them focus on their healing journey with dignity, hope, and strength.

To be eligible for this program, patients must meet the following requirements:

1. Be a U.S. Resident and reside in one of the covered counties in Central and Southern Illinois – Bond, Christian, Clay, Clinton, DeWitt, Effingham, Fayette, Jefferson, Macon, Madison, Marion, Montgomery, Moultrie, Piatt, Randolph, Richland, Shelby, St Clair, Washington, Wayne
2. In active cancer and/or hematologic treatment.
3. Be 18 or older.
4. Have a healthcare professional who can confirm a cancer and/or blood disorder diagnosis, that the patient is in active treatment and where the patient is receiving treatment
5. Have a maximum income that is 300% or less than the Federal Poverty Level (FPL). The federal poverty level is a number set by the federal government each year. FPL is based on income and family size. This number is used to determine eligibility for different federal & state benefit programs.

| Family size | 2025 income numbers (FPL) | 300% |
|---|---|---|
| For individuals | $15,650 | $46,950 |
| For a family of 2 | $21,150 | $63,450 |
| For a family of 3 | $26,650 | $79,950 |
| For a family of 4 | $32,150 | $96,450 |

Applications for grants will be reviewed and processed for open funds twice per month. Decisions will be made and applicants notified as soon as possible.

Counselor/Patient Advocate/Social Worker/Nurse Navigator may utilize discretion for immediate assistance of gas / food cards.

All donation information will be documented and tracked.

Foundation grant funds may not be used to pay for any outstanding invoices from Cancer Care Specialists of Illinois. Cancer Care Specialists of Illinois cannot financially benefit from any grant.

**Medical History Verification Form**

Form Must Be Fully Completed by a Licensed Practitioner (MD, PhD, NP, LCSW, LCPC)

Applicant First Name: _____

Applicant Last Name: _____

Applicant DOB: _____

Applicant Age: _____

Attestation:

I, _____, _____, verify that _____
Practitioner Name Credentials Applicant Name

was diagnosed with _____ on _____.
Cancer and/or blood disorder diagnosis Date of diagnosis

They are under the care of _____ at _____,
Oncologist/Hematologist Name Institution

_____.
Address, City, County, State, Zip code of Institution

By signing this form, I confirm that the information provided above is accurate to the best of my knowledge, and the individual applying for this grant is in active treatment of an oncologic and/or hematologic disease.

Practitioner Signature:_____ Date: _____

Contact Name at Facility:_____ Phone:_____

**Patient Application**

Please fax the completed application to 217-329-3319, scan and email to snail@ccsci.net, or mail the completed application to: 210 West McKinley Ave Suite 1 Attn: Shannon Nail, Decatur, IL 62526. Applications will be considered in a timely manner once a completed application is received.

Patient Information (All fields must be completed):

First Name: _____ Last Name: _____

Date of Birth: _____

Home Address: _____ Apt # _____

City/State/ZIP/County: _____

Phone: (_____) _____ - _____

Email: _____

Yearly Household Income: _____

(Please submit the first page of your most current tax return, Social Security Disability award letter for the current year or other proof of income).

Cancer and/or blood disorder diagnosis and date of diagnosis: _____

Name of Oncologist/Hematologist: _____

Name of facility where treatment occurs: _____

Address of Facility: _____

Contact Name at Facility: _____ Phone: (_____) _____ - _____

If you are in a research trial, please provide name, phone number and email of trial contact person (it not, put N/A):

_____

_____

Need request (Please provide a short statement of a current financial need including dollar amount):_____

_____

_____

_____

_____

Funds will be paid directly to vendor. Please include name, address and phone number of vendor:

_____

_____

_____

**Terms and Conditions**

Fraud – The prevention of fraud is of utmost importance to CCSI Foundation. CCSI Foundation has the right to verify the accuracy of information provided during screening. Detection of fraud or abuse will result in termination of the grant and the applicant will not be eligible to receive assistance from CCSI Foundation in the future.

Release of Information – CCSI Foundation, its employees and agents are authorized to obtain and discuss medical, treatment, therapy, financial and other information relating to patient with their healthcare providers and their staff, pharmacy, employer, insurance company, and any other person or entity working on the patient's behalf to confirm eligibility. Neither, CCSI Foundation nor any of its employees or agents will disclose any patient identifiable information to any third party except as required by law, as deemed appropriate by CCSI Foundation to resolve any potential fraud or audit irregularity, or as necessary or appropriate for CCSI Foundation to provide assistance to patient under the program. CCSI Foundation may use information and data relative to patient to develop aggregate reports as CCSI Foundation deems appropriate.

CCSI Foundation's continuation is dependent on the availably of funds and the program can be modified or discontinued at any time if funding is limited or no longer available.

Signature & Attestation - MUST BE SIGNED

Do you acknowledge that you understand and agree with the terms and conditions above? Yes or No (Circle One)

By signing this form, I attest that the information provided on this form is, to the best of my knowledge, true and accurate, the patient applying for assistance has been diagnosed with cancer and/or a blood disorder, is in active treatment and resides in an Illinois county covered under the program. If asked, I agree that I can, and will, provide documentation if requested.

Patient Signature: _____ Date: _____/_____/_____