26035 Lavender Jade Court
Kingwood, Texas 77325-6487
(281) 610-6390
info@CureLMS.com

WeCARE Grant Fund Application for Financial Assistance

Grant Fund

Section I: Patient Information (Please Print or Type)

Today's Date:	
Name (First and Last)	
Mailing Address	
City, State, Zip Code	
Phone	
E-mail	
Date of Birth	
Gender	☐ Male ☐ Female
Ethnicity	
Does the patient have health insurance?	☐ No ☐ Yes, what type? Private, Medicaid or Medicare (circle one)

Section II: Financial Need (check all that apply)

The patient needs assistance with the following cancer-related treatment expenses:

☐ Transportation ☐ Hotel Stay ☐ Meals ☐ Childcare ☐ Prescription Costs

How did you hear about our WeCARE Grant Fund?

_____ Social Worker _____ Oncologist _____ Internet _____ Brochure _____ Other: _____

Consent and Release Agreement

I declare that the information provided in this application is true and accurate to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and financial determination will be made by the Cynthia Solomon Holmes Foundation ("CSHF"). I am are that WeCARE Grants are not for living expenses such as rent, mortgages or utility payments. I hereby give permission that this application and all information provided can be sent to CSHF and discussed with my health care professional. All information reviewed is strictly confidential and for CSHF use only.

I further grant the Cynthia Solomon Holmes Foundation ("CSHF"), its legal representatives or assigns and those acting under its permission and under its authority the use, re-use, publish and re-publish of my name, photo, award and the purpose of award without restriction in any medium or form. I hereby also release and discharge its successors and assigns, its officers, employees and agents, and members of the Board of Directors from any and all claims and demands arising out of or in connection with the use of such information, including, but not limited to any claims of defamation or invasion of privacy.

Print Patient Name: _____

Patient Signature: _____ Date: _____

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Section III & IV to be completed by Social Worker or Member of Treatment Team (clinician)

Section III: Treatment Center (please print or type)

Hospital / Clinic Name	
Oncologist Name (First and Last)	
Hospital / Clinic Address	
City, State, Zip Code	
Oncologist Phone	
Date of Diagnosis	
Type of Sarcoma or Rare Cancer	
Social Worker (First and Last)	
Social Worker Phone	

Section IV: Current Treatment (check all that apply)

☐ Chemotherapy ☐ Radiation Treatment ☐ Surgery ☐ Bone Marrow Transplant

☐ Hospice/Palliative Care

Date of Last Treatment _____

Physician Confirmation

I attest that the patient listed in this application has been diagnosed with Leiomyosarcoma (LMS), Sarcoma or other rare cancer and is currently being treated as stated above.

Physician Name (please print): _____

Physician Signature: _____ Date: _____

Healthcare Professional Name and Title: _____
(Person completing form -Oncologist/Oncologist Nurse/Social Worker Only)

Healthcare Professional Signature: _____ Date: _____

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CSHF WeCARE Grant Fund Guidelines and Criteria

Grant Requirements

- A photograph of the application must be submitted with the completed application to be used by CSHF promotional materials, including the Foundation's website.
- Patient must have a Sarcoma Cancer or other rare cancer diagnosis and be in active treatment.
- Active treatment includes chemotherapy, radiation therapy, bone marrow transplant, surgery, hospice or palliative care, with a recovery period in excess of 4 weeks. Active treatment does not include hormone therapy.
- Patient travel distance from address listed on the application to the treatment center must be at least 50 miles or more.
- Patients must reside and be in active treatment in the United States.
- **The application for assistance must be completed and signed by the patient, treating physician and a social worker or other health care professional.**
- Grant awards are issued on a quarterly basis at the discretion of CSHF and do not require a means test.

Eligible Requests

- CSHF approves requests for expenses incurred by adults (18 years or older) in active treatment for Leiomyosarcoma (LMS), Sarcoma or other rare cancer (defined as affecting fewer than 200,000 Americans for:
    - Air transportation to treatment center
    - Ground transportation to and from treatment center
    - Hotel rooms during treatment
    - Meals during treatments
    - Childcare during treatment
    - Complimentary therapy, including massages and acupuncture
    - Insurance or Prescription Co-payments

Ineligible Requests

- The CSHF WeCARE Grant Fund does not provide financial assistance for basic living expenses.
- Applications for cancers other than Leiomyosarcoma (LMS), Sarcoma or other rare cancer will not be approved.
- Incomplete/unsigned applications will not be reviewed.

Administration

- Mail all required materials, including the completed and signed application along with an applicant photo to CSHF at 26035 Lavender Jade Court, Kingwood, Texas 77339 or email photo to info@curelms.com.
- If approved, WeCARE Grants will be given only in the form of a check from The Cynthia Solomon Holmes Foundation made payable to the individual or entity listed as such on the application.
- Patient may only receive assistance once in a 12 month period (January – December of same year).
- Grants are awarded each quarter for a maximum of $500 per approved patient. Final approved amount will be provided to the patient upon award.

Please note: An application is not a guarantee of receiving a CSHF WeCARE Grant. Funds are limited and based on eligibility and availability.