KENTUCKY ELKS ASSOCIATION

CHARITABLE FUND

"Elks Helping Kids with Cancer"

Our Mission

The mission of the Kentucky Elks State Project, "Jim Bob Kevil" & "Kids with Cancer fund," is to provide pediatric cancer patients with monetary assistance for travel, food, and medical bills to help families cope with their child's disease and treatment. This focus is on the values that Elks members support including citizenship, family values, teamwork and responsibility, community and giving, respect, fairness and tolerance. It is the belief that each family will benefit from the "Elks Care, Elks Share" philosophy. In addition to our charitable fund a long-time member from Princeton lodge #1115, Mr. Jim Bob Kevil endowed funds specifically for helping these children & families battling childhood cancer. The "Kids with Cancer" Project shall also provide emergency funds to provide necessary equipment and services, in the absence of an outside funding source, that enable the independence of these patients. It is our hope of the Kentucky Elks Association to help relieve some of the burden that families are experiencing during this time.

The Kentucky Elks Association "Kids with Cancer" Charitable Fund, Inc. is a non-profit 501(c)(3) corporation. Your contribution is fully tax deductible to the extent that current tax law allows.

KENTUCKY ELKS ASSOCIATION
"Jim Bob Kevil" Kids with Cancer"

Financial Assistance Application

Guidelines for Assistance:

- Any child under 18 years of age receiving treatment for cancer is eligible for consideration.
- The family must be referred by their physician or assigned social worker.
- Applicant must be a resident of Kentucky and not reside in a State facility.
- Patient application forms must be completed in full. All follow ups or questions regarding the application must be made by the physician or social worker.
- All payments will be made directly to vendors. Copy of invoice from the supplier, patient name and cost to the provider, if applies, must be attached to application.
- Written verification prepared by a licensed or certified health care practitioner stating that services have been denied via other routes of payment (insurance, etc.) must be provided.

Financial Assistance is provided for:

- Doctor, Hospital or Medicine co-pays
- Medical Equipment or Supplies
- Travel Expenses and Food

Assistance Limitations:

- Maximum $1000.00 per family per year

However catastrophic expenses above $1000.00 will be evaluated on a quarterly basis and may be covered partially or in full. Because our funds are limited, there is no guarantee we can meet every request, but we will make every effort to provide assistance as we are able.

Complete the following application

E-Mail to: martincharliea@gmail.com

Kentucky Elks Association "Jim Bob Kevil" Kids with Cancer"

Charitable Fund, Inc Application

KENTUCKY ELKS ASSOCIATION
"Kids with Cancer"

Family Information:

Patient's Name: _____

Birthdate: _____**Age:** _____ **Gender: Male/Female (please circle)**

Address: _____

City: _____**, Kentucky Zip Code:** _____

Name of Parent(s) or Guardian(s): _____

Telephone: _____

Email Address: _____

Siblings and/or other family members at same address (please include ages): _____

_____

_____

_____

Health Information:

Diagnosis: _____

Date of Diagnosis: _____

Name of Oncologist/Physician: _____

Hospital/Treatment Facility: _____

Referring Social Worker/Case Manager: _____

Telephone: _____ **Fax:** _____

Email address: _____

How long have you been working with the patient? _____

Please describe the patient's current condition & needs please be specific: _____

_____

_____

_____

_____

I verify that all the information provided on this application is accurate. I understand that all information will be held in the strictest of confidence.

Parent/Guardian Signature: _____

Date: _____

Referring Social Worker Signature: _____

Date: _____

As Parent/Guardian of the child listed above, I hereby authorize the Kentucky Elks Association "Kids With Cancer" Charitable Fund, Inc. to contact our family in writing, by telephone or via email regarding the use of digital pictures of the patient and/or family so the Kentucky Elks Association can utilize these images in conjunction with its fundraising efforts. The only information that will be utilized will be the first names of family members and age of patient; no other personal information will be revealed. **Declining will, in no way, impact a decision to provide assistance.**

Parent/Guardian Signature: _____

Date: _____