



**West Virginia
Comprehensive
Cancer Control
Coalition**

**Mountains of Hope:
West Virginia's Comprehensive Cancer Control Coalition
Financial Support Application for Cancer Survivors**

Name: _____

Street
Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Have you previously participated in any Mountains of Hope coalition activities? Yes _____ No, I'm a first time participant

If yes, please discuss your past involvement:

What cancer control activities, if any, are you currently involved with:

Have you participated in the annual Agents of Hope event? Yes _____ No _____

Applying for financial assistance for (date and location of coalition meeting or activity):

Have you previously applied for Mountains of Hope financial assistance? Yes _____ No _____

If so, when?: _____

Please note: In order to ensure fair and equal distribution of financial assistance, preference may be given to active applicants who have not requested assistance during the last six (6) months.

_____ mileage. *Traveler may request mileage reimbursement at the rate of \$.20 per mile.*
Requesting funds to support (check all that apply):

_____ I *am* requesting mileage and I am willing to provide transportation for someone else. Please provide the name(s) of the person(s) riding with you.

_____ I *am not* requesting mileage, but I do need transportation to the meeting. Please provide the name(s) of the person(s) you are riding with.

_____ private hotel room *Traveler may request financial support for hotel accommodations for **one** night, if traveling more than 75 miles one way to the coalition meeting or activity. Overnight stay would be direct billed to Mountains of Hope.*

_____ I *am* requesting a hotel room and I am willing to share a room with someone else. Please provide the name of the person sharing a room with you.

_____ meals *Traveler may request a total of \$15.00 for meal reimbursement if requiring an overnight stay.*

Any special needs or special requests you would like considered for reimbursement: _____

- To submit or request an application, please contact:
Winabeth Smith, Program Manager,
Mary Babb Randolph Cancer Center
P.O. Box 6886
Morgantown, WV 26506
Phone: (304) 293-0482;
Fax: (304) 293-2287
- Applications must be submitted **30 to 60 days** prior to each coalition event/activity.
- An independent panel of the coalition will review and award any available funding and notify awardees two weeks prior to the coalition event/activity.

- If you are granted funding, mileage and meal reimbursement forms should be completed and returned to Mary Babb Randolph Cancer Center within 30 days of the event/activity or reimbursement may not be granted to the applicant.

I agree to the terms of this financial support application. I understand that financial support will be granted on an "as available basis" and such funding will be awarded by an independent panel of the coalition. I agree and understand that the organizations' sponsoring this financial support are not responsible for my care and safety to and from the coalition activity or during my hotel stay. Failing to follow the guidelines may result in failure to receive reimbursement.

Signature of Applicant _____

Date _____



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Administration of the funds courtesy of Mary Babb Randolph Cancer Center (MBRCC)*