



Maryland CANCER FUND

Certification

As the Applicant and Grantee of the Maryland Cancer Fund (MCF) Cancer Treatment Grant, we certify that the award will not be used to supplant any existing funding for cancer treatment of this individual patient.

Organization Name: _____

Patient Name: _____

- We **do not** receive any other funding for payment and/or reimbursement for the patient's cancer treatment
(that is, either we do not receive any other funding for payment or reimbursement for *any* cancer treatment activities OR we receive funding for payment or reimbursement of cancer treatment but that funding is expended or obligated to other individuals for this Fiscal Year).
- We **do** receive other funding for payment and/or reimbursement for the patient's cancer treatment as listed below, but still request MCF funds:

| Source | Title or Activity | Amount | Period for Activities |
|--------|-------------------|--------|-----------------------|
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Rationale for need for MCF Funds:

Estimated costs of cancer treatment exceed available funding for
Payment

Other _____

We, the Applicant and Grantee of the MCF Cancer Treatment Grant, further certify that:

The patient meets the residency, insurance and income requirements of the Maryland Cancer Fund program.

- We shall reimburse the provider(s), (or if we are a provider then we will accept) an amount not greater than the Medicaid or HSCRC-regulated rate (if applicable) for medical procedures performed.
- We will retain all records pertaining to this grant award for 3 years unless directed by the Maryland Department of Health & Mental Hygiene to retain longer.

We will maintain, as confidential, all medical and financial information pertaining to the patient, their treatment and his/her family.

I certify that we are (check all that apply):

A Maryland Local Health Department
A cancer screening program funded by the Maryland Department of Mental Health and Hygiene, Center for Cancer Prevention and Control:

Breast/Cervical Cancer Program
Cigarette Restitution Fund Program
Other: _____

Signature of Contact

Date

Name of Contact (Print)

Name of Organization