



**Certification for Maryland Cancer Fund Cancer Treatment Grant**

The Maryland Cancer Fund (MCF) grant money I receive, as the applicant for my organization, will not be used to supplant any existing funding for cancer treatment of this individual patient.

**Organization Name:** \_\_\_\_\_

**Individual Patient Name:** \_\_\_\_\_

- I do not receive any other funding for payment and/or reimbursement for this individual's cancer treatment  
 (that is, either I do not receive any other funding for payment or reimbursement for *any* cancer treatment activities OR I receive funding for payment or reimbursement of cancer treatment but that funding is expended or obligated to other individuals for this Fiscal Year).

- I do receive other funding for payment and/or reimbursement for this individual's cancer treatment as listed below, but still request MCF funds:

Source	Title or Activity	Amount	Period for Activities

Rationale for need for MCF Funds:

- Estimated costs of cancer treatment exceed available funding for payment
- Other \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

I, as the applicant for my organization and on behalf of any others that receive MCF Treatment Funds, certify that:

- The individual meets the residency, insurance and income requirements of the Maryland Cancer Fund program.
- (Non-MHIP applicants) I shall reimburse the provider(s), (or if I am a provider I will accept) an amount not greater than the Medicaid or HSCRC- regulated rate (if applicable) for medical procedures performed.
- I 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.
- I will maintain as confidential all medical and financial information regarding the individual receiving treatment and his/her family.

I certify that I am (check all that apply):

- A Maryland Local Health Department
- A Department of Mental Health and Hygiene, Center for Cancer Surveillance and Control funded cancer screening program
  - Breast/Cervical Cancer Program
  - Cigarette Restitution Fund
  - Baltimore City Centers for Disease Control and Prevention Colorectal Screening Demonstration Program
  - Maryland Cancer Fund Cancer Early Detection/Secondary Prevention Grantee
  - Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Contact

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Contact (Printed)

\_\_\_\_\_  
Name of Organization