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

Rationale for need for MCF Funds:

☐ Estimated costs of cancer treatment exceed available funding

☐ Other (please describe)_____

_____

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 (MDH) 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
- ☐ An Eligible Organization authorized by the MDH Center for Cancer Prevention and Control
- ☐ A cancer screening program funded by the MDH Center for Cancer Prevention and Control:
  - ☐ Breast and Cervical Cancer Program
  - ☐ Cigarette Restitution Fund Cancer Prevention, Education, Screening and Treatment Program
  - ☐ Other (please describe): _____

_____	_____
Signature of Organizational Contact	Date
_____	_____
Name of Organizational Contact (Print)	Name of Organization