



**CANCER AWARENESS CLUB FOR KIDS
GRANT APPLICATION**

General Patient Information

First Name: _____	Birth Date (mm/dd/yy): _____
Last Name: _____	Gender: _____
Mailing Address: _____	Number of Siblings and Ages: _____
Email Address: _____	_____
Daytime Phone Number: _____	

General Patient Information

<i>Mother</i>	<i>Father</i>
First Name: _____	First Name: _____
Last Name: _____	Last Name: _____
Mailing Address (If different from patients): _____	Mailing Address (If different from patients): _____
Email Address: _____	Email Address: _____
Daytime Phone Number: _____	Daytime Phone Number: _____
Are you employed? Y / N If yes, Job Description: _____	Are you employed? Y / N If yes, Job Description: _____
Employers Name: _____	Employers Name: _____
Employers Phone: _____	Employers Phone: _____
Yearly Income: _____	Yearly Income: _____

Other Forms of Income

First Name: _____	Daytime Phone Number: _____
Last Name: _____	Job Description: _____
Mailing Address (If different from patients): _____	Employers Name: _____
Email Address: _____	Employers Phone: _____
	Yearly Income: _____

Physician and Insurance Information

Primary Care Physician (PCP): _____	Name of Insurance Plan: _____
PCP Phone Number: _____	Type of Insurance: HMO / PPO / POS /
Name of Insurance Company: _____	Other: _____

Diagnosis and treatment

Diagnosis and stage of disease:

Name of Applicant: _____

Has your diagnosis been confirmed through a biopsy? Y / N
Are you currently undergoing treatment? Y/ N
Methods of Cancer Treatment:

Chemotherapy / Hormone Therapy / Radiation Therapy / Surgery / Bone Marrow or Stem Cell Transplantation / None / Other :

1. Medical-Related Costs:

Grant Amount Requested: \$ _____

Describe the medical costs or services for which you wish to use the grant:

If Medical, what portion does the insurance cover, if any?

Additional Explanation:

2. Non-Medical Costs:

(directly or indirectly related to medical treatments)

Grant Amount Requested: \$ _____

Describe the costs for which you wish to use the grant and how they are necessary in obtaining medical treatments:

For Office Use Only:

Date Grant Received: _____

By whom: _____

Date Grant Reviewed: _____

By whom: _____

Date Grant Approved: _____

By whom: _____

Amount of Grant Approved: \$ _____

Date Check Disbursed: _____

By whom: _____

Additional Comments: