Cares for Cancer, Inc.
PO Box 502
Hankinson, ND 58041

Granting Committee
caresforcancer@yahoo.com
(701) 403-9509

****Applications are due the 15th of the month****

(Award letters are sent out by the 1st day of the month following application submission)

Name of Recipient (first, middle, last)

Name: _____ Phone: _____

Address of recipient: _____ City: _____

State: _____ Zip code: _____ Email address: _____

Medical diagnosis of recipient

(Please attach: Signed documentation from physician of medical illness or condition):

_____

Request for Donation

$_____ Amount requested (maximum $500 per 90-day period)

- Documentation of medical expenses for reimbursement must be attached.
  - Medical Explanation of Benefits (EOB)
  - Mileage Log (corresponding paperwork from the physician's office documenting your appointment must accompany your mileage request.) Mileage will reimburse at $0.40/mile.
  - Prescription Drug Receipt (print out from Pharmacy must accompany the Rx bill)
  - All other medical expenses (ex. Physical therapy, dental work, assistive devices) must have a note from a Physician documenting the need for these services/appliances.

☐ **Currently under the Care of Hospice?**

- If yes, Hospice Nurse signature: _____

Any other form of assistance or aid for above stated request:

☐	Donations	☐	Health Insurance
☐	Emergency assistance	☐	Disability
☐	Medical Assistance (Medicaid)	☐	Social Security
☐	Part Time/Full Time Employment		

- If employed, please provide place of employment and hours/week: _____

_____

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How has the household income or ability to work been affected? _____

_____

_____

_____

The information contained in this application is for the purpose of obtaining funding from Cares for Cancer, Inc. on behalf of the undersigned. The undersigned understands that the information provided herein is used in deciding to grant funding and the undersigned represents and warrants that information provided is true and complete and that Cares for Cancer, Inc. may consider this application as continuing to be true and correct until a written change has been provided. Cares for Cancer, Inc. is authorized to make inquiries they deem necessary to verify the accuracy of the statements made herein. In addition, the applicant agrees to the sharing of the information provided herein with all Cares for Cancer, Inc. members.

I understand that by signing this application, I am agreeing that my name, the purpose of the Cares for Cancer, Inc. grant and the amount maybe published, should this application be successful.

Also, by signing below I verify that I am within a 40-mile radius of Hankinson, ND or a resident within Richland County. I also understand that I can reapply for these funds every 90 days after the time I am granted the funding.

*** Applications must be signed by the recipient or legal representative.**

_____ _____

Signature of Applicant Date

PLEASE USE THE CHECKLIST BELOW TO MAKE SURE YOU HAVE ALL PROPER DOCUMENTATION ENCLOSED WITH THIS APPLICATION. IF THE FOLLOWING INFORMATION IS NOT INCLUDED YOUR APPLICATION WILL BE CONSIDERED INVALID AND WILL NOT BE CONSIDERRED FOR THIS GRANTING PERIOD.

☐ **Signed documentation from physician of medical illness or condition.**

☐ **Specific documentation of medical expenses totaling at least $500.00 (Please see guidelines as requirements for proof of expenses has changed).**