APPLICATION FOR NON-MEDICAL EXPENSES
CANCER COALITION of SOUTHWEST COLORADO GRANT

PATIENT INFORMATION (PLEASE PRINT CLEARLY AND COMPLETE IN ENTIRETY!) READ THE GUIDELINES ON THE REVERSE SIDE FOR FURTHER INFORMATION. PLEASE ATTACH A NOTE FOR ANY CLARIFICATION.

DATE________________________

First Name___________________________Last Name___________________________

Address (Street)____

(City)____________________________________(State)_________(zip code)_________

Mailing address if different____

Home Phone ____________________________Cell phone ______________________

Marital Status ____________ #in household____ #children in household_____________

Total Annual Household Income _______________Monthly Income________________

Cancer type_______________________________ In treatment now? ______________

Date treatment start? ______________Date treatment complete?____________________

Have you ever received a CCSWC grant in the past? ______If yes, when? _____________

HEALTH CARE PROVIDER OR REFERRING INDIVIDUAL INFORMATION: (physician, nurse practitioner, physician assistant, nurse or social worker)

Name_______________________________Position ____________________________

Facility____________________________________ Telephone ____________________

Health Care Provider/Referral Signature _______________________Date____________

REQUESTED FUNDING INFORMATION

Please indicate for which item you are seeking funding and the amount needed by the appropriate category. Please state to whom the check should be made.

Recipient categories: **Write check to:** **Amount:**

Household/utilities, etc.____ ______

Groceries____ ______

Car payment____ ______

Mortgage assistance____ ______

Gas cards at Cancer Resource Center____

How did you hear about this grant?

______Durango Cancer Center _____CCSWC brochure ____ACS Cancer Resource Center

______Friend _____Other

Patient Signature _______________________________________Date__________________

By signing this form I am consenting to disclosure of information on this application to the Cancer Coalition of SW CO and exchange of information between my health care provider or referring individual and the Cancer Coalition as relevant to this application process.

Submit your application to:

Cancer Coalition of Southwest Colorado, P.O. Box 1455, Durango, CO 81302 tel: 970-799-1654

Revised: 1/2017, 1/2018, 9/2018