Grant Application

Criteria:

- You must be a legal resident of Union County, Arkansas, and show proof of residency (driver's license, social security card, voter registration, insurance records, etc.)
- You must, at the time of application, be currently under treatment for cancer, and must provide proof from you doctor.
- You may submit only bills that no insurance company or other charitable organization paid, and you must provide copies of the bills you are applying for assistance for.

Date of Application: _____ Application Completed By: _____

Patient Information

Full Name of Patient _____ Date of Birth_____
Last First MI

Address: _____
Street Address

_____
City State ZIP Code

Daytime Phone: _____ Alternate Phone: _____

Email Address: _____

Marital Status: Single Married Divorced # of People in Household _____

Patient's Place of Employment: _____

Additional person(s) that we may speak to regarding your application:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Insurance and Financial Information

Do you have medical insurance? Yes No
Including Medicare, Medicaid, or private coverage

If yes, list provider: _____

I attest that I have read the policies and guidelines for #teamcorrie Cancer Foundation patient grant program. Furthermore, I certify that my answers on this application are true and complete to the best of my knowledge.

Completion of application does not guarantee a grant will be awarded.

Signature: _____ Date: _____

***Application must be returned with copies of at least $1000 in cancer-related medical bills not paid for by insurance. These may include travel expenses such as mileage, gas, hotel bills, food,

Please submit to:

#teamcorrie Cancer Foundation

145 Parker Drive

El Dorado, AR. 71730