**DATE RECEIVED:**_____

**DIRECTOR SIGNATURE:**_____

S.E.C.C.I.
Southeast Colorado
Cancer Initiative

# APPLICATION FOR FUNDING:

**NAME OF APPLICANT:**

_____

**MAILING ADDRESS:**

_____

_____

**PHYSICAL ADDRESS:**

_____

_____

**CONTACT INFO:**
**Cell#:**_____ **Alternate#:**_____
**Email:**_____

**PERSONAL CARE REPRESENTATIVE(S):** ***Applicant MUST LIST at least 1x personal care representative****

1.) **Name:** _____
**Phone#:**_____
**Email:**_____

2.) **Name:** _____
**Phone#:**_____
**Email:**_____

**FUNDING REQUESTED:** ***Check all boxes that apply****

1.) **Emergency:** ☐ 2.) **Fuel Fill-Up:** ☐ 3.) **Receipt Reimbursement:** ☐

**PHYSICIAN AND DIAGNOSIS:** ***Attach Official Diagnosis Documentation to application****

_____

_____

_____

_____

_____

_____

**DATE WHEN FUNDING IS NEEDED:**

_____

**TIME FRAME FOR ASSISTANCE:** **Attach *Treatment Plan and Timeline from Oncologist**

_____

****ALL APPROVED FUNDING REQUESTS ARE SUBJECT TO A REVIEW IN 30-DAYS or BY THE NEXT REGULARY SCHEDULED BOARD MEETING.****

**SIGNATURE OF APPLICANT:**_____

**SIGNATURE OF REPRESENTATIVE:**_____

**SIGNATURE OF REPRESENTATIVE:**_____

**BOARD REVIEW DATE:**_____ **BOARD DECISION: Approved**_____ **Denied**_____

**REASON FOR DENIAL:**_____

**SIGNATURE OF PRESIDENT:**_____

**SECCI Contact Info — Email: seccipres@gmail.com Phone: 719.691.0136**