grant county cancer coalition

lighting the way through research and recovery

ATTN: Application Committee
Grant County Cancer Coalition
PO Box 105
Lancaster, WI 53813

Applicant
Name _____ Phone _____
(please print)
Address _____ County _____

Please provide name and phone number of additional contact to act on your behalf:

Additional Contact Person _____ Phone _____
(please print)

Diagnosis _____

Physician _____

Request for Assistance: Please explain in detail the assistance you are requesting from Grant County Cancer Coalition. Please be very specific about why you need the financial assistance and what sort of help you need. Some examples are gas cards, grocery cards, utilities bills, house or rent payment, medical and pharmacy bills: _____

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Applicant Signature **Date**

For Office Use Only

Grant County Cancer Coalition Board Approval Date _____
(*board signature and date*)

_____ _____
(motion to approve) *(second to approve)*

Phone call to applicant to inform of approval (Yes)_____ ***Note***_____

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