



grant county
cancer coalition

lighting the way through research and recovery

APPLICATION FORM

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

Applicant Name _____
(please print)

Phone _____

Address _____ County _____

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

Additional Contact Person _____ Phone _____
(please print)

Diagnosis _____

Physician _____

I verify that I currently am living in Grant County Wisconsin and have a cancer diagnosis. I am requesting assistance from the Grant County Cancer Coalition.

(Applicant's signature)

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: _____

Applicant Signature

Date

For Office Use Only

Case No. _____

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 _____