Patient Grant Application

Patient Name____

Address/Phone Number/E-Mail____

____

Contact Person/Provider Recommending Help:___________________________________

Physician, Nurse, Social Worker, Family Member:______________________________

Address/Phone Number/E-Mail: ____

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Cancer Diagnosis:______________________________ Oncologist:_________________________

Has the patient agreed that this information be shared with CROC? _______Yes _______ No

Patient Signature ______________________________________ **Date:**__________________

Why do you feel that this patient is in need of some assistance? Due to confidentiality restrictions, please **DO NOT** share personal information without prior signed approval by patient.

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Needs (please check):

Transportation _______ Medical Expenses/Co-Pays _______ Living Expenses _______ Dental Expenses ______

Other (Please Explain) ____

Required: Please submit copies of bills or paid receipts totaling $750 or more along with application. Please note grant amount is for maximum amount of $750 unless special need is demonstrated. Due to volume this is a one-time gift opportunity in order to allow the CROC organization to assist as many people as possible.

Mail application to: CROC – Citizens Reunited to Overcome Cancer

PO Box 860

New Hampton, New York 10958

myriamloor@hvc.rr.com

These restricted funds have been made possible through **Celebrate Life Half Marathon** in Rock Hill, New York. Please allow 4 – 6 weeks for processing.

How did you hear about us? ____