Patient Grant Application

Patient Name_____

Address/Phone Number/E-Mail_____

_____

Contact Person/Provider Recommending Help:_____

Physician, Nurse, Social Worker:_____

Address/Phone Number/E-Mail: _____

_____

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.

_____
_____
_____
_____
_____

Needs (please check):

Transportation _____ Medical Expenses/Co-Pays _____ Living Expenses _____ Dental Expenses _____

Other (Please Explain) _____

Required: Please note grant amount is for maximum amount of $1,000 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

E-mail myriamloor@hvc.rr.com Fax 845 333-1966

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? _____