Spierings CANCER FOUNDATION

SCF Family Grant Application

Recipient Name:_____

Age:_____

If minor provide parent(s) name:_____

Recipient Address:_____ City:_____ State:_____ Zip:_____

County:_____ Phone:_____

Email address:_____

Have you received a grant from SCF before? Yes_____ No_____If so when_____

Hospital where recipient is currently being treated:_____

City_____ County_____

Please attach a photo: For Spierings Cancer committee use only

Will you be willing to share your story or picture on our website, face book or other promotional media. Yes_____ No_____

Cancer history

What type of cancer have you been diagnosed with? Please give a brief description.

_____

_____

_____

When were you diagnosed?_____

Are you currently receiving treatments? Yes _____ NO_____

What type of treatments are you receiving?_____

_____

How long are you expected to be receiving treatments?_____

Financial history

Married_____ Single_____ How many dependants:_____

Are you currently working? Yes_____ NO_____

Part time:_____ How many hours per week:_____ Full time:_____

Retired:_____

If currently not working how long have you been out of work?_____

How long are you expected to be out of work because of treatments?_____

Is your spouse working? Yes____ No____

House hold monthly income:_____

Has your monthly income decrease since you have been in treatments?_____

If so by about how much?_____

Monthly expenses:

house, rent payments:_____

Utility, phone, cable:_____

other expenses:_____

Medical expenses:_____

Total monthly expenses:_____

Do you have insurance: Yes_____ NO_____

Description of insurance including deductibles, co-pays ext?_____
_____

Are you receiving any kind of disability or government assistance: Yes_____ No_____

Physician Confirmation

Please provide your physician's signature confirming the applicant is currently, or has recently undergone cancer treatment:

I, _____ (physician's name), do hereby confirm that,

_____, (patient's name) is currently undergoing, or has recently undergone treatments for cancer at, _____, (hospital name/cancer center).

Physician's signature _____ Date _____

All request must have Physician signature and a photo of the recipient.

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700 Harvest Trail, Appleton WI. 54913