Spierings CANCER FOUNDATION

Family Grant Application

Recipient Name:_____

Age:_____ Is applicant a minor?_____

If yes, please 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 SCF use only

Will you be willing to share your story or picture on our website, facebook 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 decreased 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___