Harrington Cancer And Health Foundation

Grant Application
For
Cancer Patients in Need of Support

Applicant's Name:____

Address:____

City, State: ____ **Zip:**__________________________

Phone Number:__________________________ **Email:**____

Date of Birth:____________________________**Age:**____

Local Oncologist:____

Primary Diagnosis:____

Date of Diagnosis:____

Oncologist Office Signature (REQUIRED)**:**____

Form Completed by: (Please fill out if other than applicant)

Name:____

Address:____

____

Phone Number:__________________________ **Email:**____

____ ________________________

Applicant/Family Member Signature **Date**

1. **Briefly identify the need(s) <u>(Include copies of bills you would like to be considered):</u>**

2. **Total amount requested (identify how this $ amount was determined and name and address of agency, store, pharmacy, etc. HCF would pay).**

3. **Have other resources been explored to meet identified needs? ____Yes _____No**
   If yes, identify resources explored and if not, why?

   Have you applied to Panhandle Cancer Cure Foundation (PCCF)? _____ Yes _____ No

4. **How is the applicant's health care paid for? (i.e. Medicare, Medicaid, District Clinic, VA, Insurance, CIDC, Private Pay). If this is in regards to dental care, does the patient have dental insurance?**

5. **Briefly describe the applicant's situation (family size, ages of family members, employment, marital status, treatment status, etc.).**

6. **Identify Sources of income and monthly expenses (Include 3 pay stubs):**

Monthly Income

Sources of Income 18 and Older in household	Patient	Spouse/Other
	$	**$**
Salary/wages	$	$
Pension	$	$
Social Security	$	$
Supplemental Security Income(SSI)	$	$
Unemployment Comp.	$	$
Veteran's Benefits	$	$
Food Stamps	$	$
TANF	$	$
Child Support	$	$
Savings, Stocks, Bonds, Cd's, etc.	$	$
HUD	$	$
Other	$	$

Total of Both Incomes	**$**

Monthly Expenses

(Check one) _ Mortgage _ Rent _ Own Home	$
Food	$
Utilities: Heat $___________ Electric $____________ Water $_____________ Telephone$______________ Cable $______________Cell Phone$______________	$
Insurance Premiums: Life $_____________________ Property $_____________ Medical $_____________ Auto $____	$
Installment Debt	$
Medical Expenses not covered by third party or insurance: Medication $________________________ Doctor or Hospital $ __________________________	$
Transportation: Car Payment $________________________________ Gas Expenses$________________________________	$
Child Care	$
Other (specify)	$

Total Expenses	**$**

Upon Completion, please submit one of the following ways:

- Email to haleybell@hchfamarillo.org
- Fax to Haley Bell at 806-331-6942
- Mail your application to the Harrington Cancer and Health Foundation Office located at 500 S. Taylor, Suite 1060, Unit #223, Amarillo, TX 79101.

REQUIRED for application processing.

*** Please include supporting documentation with application. A copy or the original of the bill, estimate, payment coupon or letter from landlord must accompany the application.**

All payments are made directly to businesses and not individuals. Assistance for gas is given in the form of gas cards.