CANCER RESOURCE ALLIANCE

of Montezuma and Dolores Counties

P O Box 569 Cortez, CO 81321

Application for Financial Assistance (revised 7/18)

Name: ____ DOB _____________________

Mailing address: ____

Physical address: ____

Email address:____

Home Phone: _______________________Cell Phone:__________________________________

Who referred you to our group? ____

Cancer type: ____

Date treatment / testing began or will start____

Do you have insurance coverage and what type? Private _____________________________

Medicare ______________ Medicaid __________________ None ____________________

Have you received funds from the Cancer Resource Alliance in the past? Yes / No

_____ This application is for MEDICAL expenses (i.e. cancer screenings, further diagnostic testing, treatments, prescriptions, insurance deductible, etc.)
_____ This application is for NON-MEDICAL expenses (i.e. transportation or living expenses while you are in treatment)

Please list expenses you would like assistance with and the amount:

Item	Amount

In order to receive financial assistance, please attach a physician's statement of cancer diagnosis or testing.

- Please mail this application to: Cancer Resource Alliance, P. O. Box 569, Cortez, CO 81321
- For questions, please call Sue at 970-759-9623

Funds are available up to $500 per person.

Signature ____ Date______________________________