GRACE FOUNDATION
Grand Island Area Cancer Endowment

P.O. Box 5111
Grand Island, NE 68802
(308) 675-0889

PATIENT INFORMATION (Please print clearly) Today's Date: _____

First name: _____ Last name: _____

Address: _____ City: _____

Phone number: Home ( ) _____ Cell/Mobile ( ) _____

Email Address: _____

Date of Birth: _____ Male _____ Female _____ Are you a veteran? _____

Social Security Number: _____-_____-_____ Primary Race: _____ Ethnicity: _____

If patient is a minor (under 18), name of parent or guardian _____

Marital Status: Married Single Divorced Separated Cohabitate

MEDICAL INFORMATION ***_This section must be completed by your oncology nurse, doctor or hospital patient navigator_***

Date of Diagnosis: _____ Primary Cancer: _____ Current Stage: _____

New Diagnosis: _____ Recurrence: _____ Is patient in active treatment? _____

If not in active treatment, indicate frequency of follow-up: Yearly_____ Monthly_____ Other _____

List types of treatment received in the past twelve months: _____

_____

Health Care Professional Information

MD name: _____ Hospital/Clinic _____

Address: _____ City _____

Phone: ( ) _____ Fax ( ) _____

SIGNATURE _____

(1-2015)

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED

HOUSEHOLD FINANCIAL INFORMATION (Please do not leave any information blank. If value is zero please write $0.00)

Is patient currently employed?_____Number of immediate family members in household? _____

Name:_____ Date of Birth:____/____/____ Name:_____ Date of Birth:____/____/____
Relationship: Spouse, Partner, Child, Other:_____ Relationship: Spouse, Partner, Child, Other:_____

Name:_____ Date of Birth:____/____/____ Name:_____ Date of Birth:____/____/____
Relationship: Spouse, Partner, Child, Other:_____ Relationship: Spouse, Partner, Child, Other:_____

Name:_____ Date of Birth:____/____/____ Name:_____ Date of Birth:____/____/____
Relationship: Spouse, Partner, Child, Other:_____ Relationship: Spouse, Partner, Child, Other:_____

Family Income Sources (please list all that apply)

$_____Social Security (retirement) $_____Salary $_____Pension $ _____SSI $_____SSD (Disability)

$_____Unemployment $_____Public assistance $_____Short-Term Disability $_____Family/friends Support

$_____ Other - specify _____

Rank up to three areas of greatest need and give details. **Amount Requested $**_____

_____Transportation _____Housing _____Co-Pays/Premiums _____Utilities

_____Medical Expenses _____Caregiver _____Living Expenses

_____Other - specify: _____

_____

Please be aware that funds are limited, and based on availability as well as on meeting GRACE Foundation's eligibility requirements.

SIGNATURE_____ ***DATE*** _____

I ATTEST BY WAY OF MY SIGNATURE THAT ANY FINANCIAL ASSISTANCE GRANTS WHICH MAY BE AWARDED WILL BE UTILIZED FOR THE EXPENSES INDICATED ABOVE

Requests can be mailed or delivered to:
GRACE Foundation
3310 West Capital Ave
P O Box 5111
Grand Island, NE 68802
308-675-0889

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