Officials against Cancer

Health Grant Assistance Application

First Name

Middle

Last Name

Street Address

City

State

County

Zip

Is the patient applying for assistance with bills for current and/or future services?

Is the patient applying for 100% assistance with their bills for services?

What Hospital is the patient currently receiving treatment?

Family Size Monthly Household Income

I certify that all information is valid and complete and hereby authorize Official against Cancer to request information from the Hospital.

Applicant Date Co-Applicant Date