First City
COUNCIL ON CANCER

P.O. Box 8832
Ketchikan, AK 99901
FCCancer1@hotmail.com
www.firstcitycouncilоncancer.org

APPLICATION FOR ASSISTANCE

Name: _____Birthdate: _____

SSN: ____-____-_____ Address: _____

City: _____ Zip Code: _____ Phone:_____

E-mail: _____

Diagnosis: _____

Assistance to be awarded as follows:

- Award:
  - Disbursement up to $3000 after initial diagnosis for reimbursable expenses
- Subsequent requests/awards:
  - Additional funds may be awarded every six months, dependent upon the availability of funds.

All applications are reviewed twice monthly. Please note that a submitted application is not a guarantee of receiving funds.

Financial Assistance is given for medical treatment or travel related expenses.

Expenses considered for reimbursement are: travel, lodging, meals, car rental and any medical bills not covered by insurance. We do not currently reimburse for any other items.

*Please note that we are only able to reimburse for documented expenses incurred by the applicant and we must have the original receipts for our records.

Disclaimer:

First City Council on Cancer is a nonprofit organization, run by volunteers. Once an application and receipts are submitted please allow 4-6 weeks for processing. Please know that we work tirelessly to ensure that funds are available for assistance, however funding is dependent on what is available at the time of the request.

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Physician Statement of Diagnosis

Date: _____

_____ has been diagnosed with _____.

Applicant's Name Type of Cancer

This statement serves as verification for a grant application for reimbursement of monies spent on care and travel related to the above diagnosis.

Diagnosing Provider: _____

Signature

_____

Print Name

_____

Clinic Name

_____

Phone Number