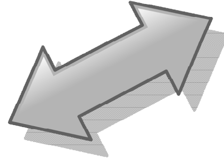
FIRST CITY COUNCIL ON CANCER



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

APPLICATION FOR ASSISTANCE

Name: ________________________ Date: ____________________

Birthdate: ____________________ SSN: _______-______-______

Address: __________________ City: ________________________

State: ______________________ Zip Code: __________________

Home Phone: _______________ Cell Phone: _________________

Diagnosis: ____

E-mail: ____

Assistance to be awarded as follows:

AWARD:

- Disbursement up to $3,000.00 after initial diagnosis for reimbursable expenses.

SUBSEQUENT REQUESTS/AWARDS:

- Additional funds may be awarded every six months, dependent upon the availability of funds. 3-year limit, not to exceed $8,000.00.
- All applications are reviewed twice monthly. Please note that a submitted application **is not** a guarantee of receiving funds.

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

Expenses considered for reimbursement are travel, lodging, meals for the applicant and caregiver, 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. Also, the entire application must be filled out and all 3-pages returned via US mail along with your original receipts. Please keep a copy of the packet for your own records.

DISCLAIMER:

First City Council on Cancer is a nonprofit organization, run by volunteers. Once an application and receipts are submitted please allow 2-4 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.

FCCC USE ONLY

$Receipts	Date Paid	Amount Paid	$Receipts	Date Paid	Amount Paid

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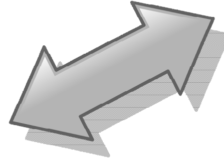

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PHYSICIAN'S STATEMENT OF DIAGNOSIS

Date: ________________ ________________________________

(Applicant's Name)

has been diagnosed with ___________________________________

(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)