



**The Ellsworth County Cancer Fund**  
Assisting families dealing with cancer  
**APPLICATION**

**Patient Information:**

Name: \_\_\_\_\_ SS Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone (Day): \_\_\_\_\_ Phone (Eve): \_\_\_\_\_ Email: \_\_\_\_\_

**Applicant/ Contact Person- if different from patient**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone (Day): \_\_\_\_\_ Phone (Eve): \_\_\_\_\_ Email: \_\_\_\_\_

I have been diagnosed with cancer (or am submitting this application on behalf of a minor who has been diagnosed with cancer) and require assistance with costs associated with my treatment. I hereby give permission to the staff of the Smoky Hills Charitable Foundation and the Greater Salina Community Foundation to contact the parties listed in this application or attachments thereto for purposes of verification.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant

Please attach the following information to this cover sheet:

- ◆ A brief medical history, including condition of the patient with regard to cancer.
- ◆ A brief statement of financial need, including information about any medical insurance and expenses covered by the insurance policy.
- ◆ A statement from applicant's medical doctor attesting to the medical conditions and necessary treatment. (*The attached form may be used for this. Please fill out all the information highlighted in yellow and give to your doctor to release the information to the Foundation.*)
- ◆ A listing of expenses, real or projected, for which the grant is being requested.
- ◆ A timetable for the expenditure of the grant.

Smoky Hills Charitable Foundation  
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