MARYLAND CANCER FUND

Organization Application

(Please Type or Print Clearly)

Information about Applicant Organization

Name of Organization: _____

Name of Contact Person: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Information about Individual Requiring Cancer Diagnosis and/or Treatment

Name of Individual: _____

Date of Birth: _____

Gender: _____

County of Residence: _____

Type & Stage of Cancer: _____

☐ **New patient application OR** ☐ **Re-enrollment application** _____

(Previous ID#)

Please complete the following checklist for enclosures:

- ☐ Completed MCF Cancer Treatment Application, along with:
  - ☐ Proof of health insurance policy, if applicable
  - ☐ Proof of residency eligibility
  - ☐ Proof of annual family income or notarized statement of no income
- ☐ Physician letter (on physician's letterhead confirming individual diagnosed with cancer, treatment for cancer, or finding suggestive of cancer, date of diagnosis or treatment, specialty, medical license number)
- ☐ Treatment Plan and Budget
- ☐ Certification
- ☐ Consent
- ☐ Fiscal Budget Forms DHMH 432 A – H