MARYLAND CANCER FUND

Treatment Plan and Budget

Name of Organization/Entity applying for Grant: ______________________________

Patient Name: ______________________________ Date of Birth: ______________________________

Diagnosis: ______________________________ Date of Diagnosis: ______________________________

Comments: ______________________________

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Treatment Plan from ____________ (date) to ______________ (date) Primary Treating Physician's Name: ______________________________

Procedure and Frequency of Treatment	**Date Anticipated**	**Estimated Costs**	**Basis for Costs (Medicaid rate, HSCRC-regulated rate, or out of pocket insurance costs)**
Sub Total for Treatment			
Indirect costs (Maximum of 7%)			
Total Requested (Treatment + Indirect)			