



Maryland CANCER FUND

Cancer Treatment Plan and Budget

Name of Organization/Entity applying for Grant: _____

Patient Name: _____ Date of Birth: _____

Diagnosis: _____ Date of Diagnosis: _____

Comments: _____

Treatment Plan from _____ to _____ Primary Treating Physician's Name: _____
(date) (date)

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)			