



Maryland CANCER FUND

Organization Application

(Please Type or Print Clearly)

Name of Contact: _____

Name of Organization/Entity: _____

Address: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Name of Individual Patient Requiring Cancer Treatment: _____

Date of Birth: _____

Gender: _____

County of Residence: _____

Type & Stage of Cancer: _____

Please complete the following checklist for enclosures:

- Completed treatment application: Non-MHIP Treatment Application or copy of Maryland Health Insurance Plan [MHIP] Application, along with:
 - 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