



**Organization Application for Maryland Cancer Fund Cancer Treatment Grant**

Please Print or Type Clearly

(Please complete for each individual in need of treatment.)

**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:** \_\_\_\_\_

**How did the individual patient learn of the Maryland Cancer Fund treatment grant?**

\_\_\_\_\_

**Please complete the following checklist for enclosures:**

- Completed treatment application form (either Maryland Health Insurance Plan [MHIP] or Non-MHIP Treatment Application) for each individual for whom grant funds are being requested, including:
  - 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 (See template)
- Maryland Cancer Fund Cancer Treatment Plan and Budget
- Certification for Maryland Cancer Fund Cancer Treatment Grant
- Fiscal Budget Forms DHMH 432 A – H (as applicable)