

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 for (date) _____ to (date) _____

Primary Treating Physician's Name: _____

Procedure and frequency of Treatment	Date Anticipated	CPT Codes Anticipated (if applicable)	Estimated Costs	Basis for costs (Medicaid or HSCRC-regulated rate for each procedure; OR MHIP rates)
Sub Total for Treatment				
Indirect costs (Maximum of 7% of total for Local Health Departments, 10% for non-LHD applicants)				
Total Requested (Treatment + Indirect)				