

STATEMENT OF PURPOSE

Please describe what the grant support will be used for _____

Estimated cost _____

Please explain how this grant would assist you and contribute to your quality of life.

FINANCIAL & MEDICAL ASSISTANCE INFORMATION

Income: (Monthly)

Expenses: (Monthly)

Net Income _____

Rent/Mortgage _____

Social Security _____

Utilities _____

Public Assistance _____

Telephone _____

Other Income/Grants _____

Food _____

TOTAL _____

Medications _____

Other _____

Savings (Total)

TOTAL _____

Savings _____

Stocks, Bonds, CDs _____

Investments _____

TOTAL _____

Insurance Carrier _____

How did you hear about our Patient Aid Grant program? _____

CERTIFICATION AND DISCLAIMER

I certify that the foregoing information is true and correct. If my application for a Cure for Cancers Patient Aid Grant is accepted, I understand and agree that there are risks, both foreseeable and unpredictable, associated with transportation, housekeeping services, equipment, or other goods, programs, or services funded by this grant. I am aware of these risks and agree that my use of these goods or services is at my own risk. I hereby agree that Cure for Cancers, nor its officers, directors, employees, agents, members, or volunteers, shall not assume or have any responsibility or liability, including without limitation of any kind in connection with this grant liability for expenses or medical treatment or compensation for any injury I may suffer during or resulting from my use of the CfC grant. I do hereby, for myself, my heirs, executors, and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my use of this or any future grant funding. I give CfC or their designee permission to contact my physician (nurse/social worker when applicable) based on the information I have provided within this grant application. I will comply with any rules or restrictions related to the terms of this grant if I should be a recipient.

Signature_____

Date_____

**Please return this completed form and mail it to:
Cure for Cancers
3260 Shasta Circle North
Los Angeles, CA 90065
Phone 1-866-332-CURE Fax 323-982-9818**