HATTERAS ISLAND CANCER FOUNDATION, INC
PO BOX 442
HATTERAS, NC 27943

APPLICATION FOR GRANT FOR INDIVIDUALS OR FAMILIES

Hatteras Island Cancer Foundation grants shall be disbursed for lodging and medical expenses related to a cancer illness. **Funds will be paid directly to medical facilities, pharmacies or motels.**

Applications for grants should be accompanied with copies of bills for services or documentation of housing requirements.

The person signing this application warrants that the information provided is true. Hatteras Island Cancer Foundation is authorized to make all inquires deemed necessary to verify the accuracy of the statements herein.

Applications should be mailed to Hatteras Island Cancer Foundation at PO Box 442, Hatteras, NC 27943 . Grant applications are reviewed the first week of every month. Information provided in the application will be kept in strictest confidence.

________________________________ ____________________
Signature of Applicant Date

APPLICANT INFORMATION

Name____
First Middle Last

Social Security Number__________________Date of Birth__________________

Physical Address____

Mailing Address____

____

Home Telephone __________________ Work Telephone__________________

Employer of Applicant____

Address of Employer____

Supervisor Name____

Other members of household (those living with applicants)

Full Name	Relationship	Age
______________________________________	___________________	_____
______________________________________	___________________	_____
______________________________________	___________________	_____
______________________________________	___________________	_____
______________________________________	____________________	_____

List employment of other members of household

Name	Employer
______________________________________	_____________________
______________________________________	_____________________
______________________________________	_____________________

Type of Cancer _________________________Date of Diagnosis________________
Primary Care Physician____

Do you have medical insurance? Yes or No
If yes, Name of primary insurance company:________________________________
Name of secondary insurance company:______________________________
Do you have supplemental cancer insurance. If so, name of insurance company:______________________________-

Has anyone in this family applied for a grant from the Hatteras Island Cancer Foundation?
Yes______No______ Date_______________ If yes, name of person in household:__________ Granted Yes____No______

Reason for request____

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Amount requested by this application $____________

Reason for request. You must include specific use of funds. Please include bills documenting expenses and/or lodging expenses anticipated by applicant during your cancer treatment.

HOUSEHOLD INCOME

Applicant wages – monthly __________

Spouses wages – monthly __________

Child Support –monthly __________

Unemployment – monthly __________

Other – monthly __________

Total Household Income ______________

HOUSEHOLD EXPENSE

Rent/Mortgage – monthly ___________

Utilities – monthly ___________

Child Care – monthly ___________

Medical – monthly ___________

Insurance – monthly ___________

Other – monthly ___________

Total Household Expense _______________

DO YOU HAVE ADDITIONAL FUNDS THAT COULD BE DRAWN FROM (such as checking, savings, stocks, bonds, retirement funds)

- ❑ NO
- ❑ YES
- ❑ If YES , please list the value of the assets
  - ❑ 10,000-25,000
  - ❑ 25,000-100,000
  - ❑ Over 100,000

TRAVEL REIMBURSEMENT DOCUMENTATION

Grant in the Name of ________________________________

Address: ____

____

Date(s) of Travel: ____________________________________

Destination: ____

____

Purpose of medical visit: ____________________________

Total mileage this trip: _______________________________

Travel reimbursement forms may be mailed to PO Box 442, Hatteras, NC 27943 or dropped off at either HealthEast clinics on Hatteras Island.