Application for Financial Assistance and Attestation of Applicant

Personal Information	
Applicant Name:	Date of Birth:
Intended Use of Requested Funds or Bills Submitted:	Amount Requested: $
Mailing Address: City, State & Zip Code:	
County:	Phone (Cell or Home):

Please confirm the factors of your eligibility:

1) ___ I am currently being treated for a cancer diagnosis, which has created a financial need due to new or additional expenses or as a result of loss of income; and

2a) ___ I reside in Phelps County, Missouri or within a 45 mile radius of Rolla, Missouri; or

2b) ___ I am a Missouri resident being treated for a diagnosed cancer whose treatment provider and treatment occurs in Phelps County, Missouri.

Summary for Application and Need for Assistance

Miles traveled to treatment (Round Trip):_____ Number of trips per month:_____

Additional Expenses or Loss of Income Information:

In consideration for approval of your application for assistance, please complete this attestation by initialing each item, sign below and submit. *This form should be completed by parent or guardian, if applicant is under 18.*

____ I have answered all questions in this application truthfully and to the best of my knowledge and I am not receiving other financial assistance for the expenses which I am seeking assistance with in this application.

____ I understand that while every effort will be made to provide assistance, it is limited to availability of funds, I may not receive assistance even if I satisfy the eligibility requirements and other terms and conditions of the grant guidelines, and that no payments will be made automatically. I understand the grant guidelines and eligibility criteria could be modified at any time or discontinued at any time.

____ I understand that The Cancer Gala Board has the right to request additional information, review my eligibility and accuracy of any documents or information I provide in my application. I understand that The Cancer Gala Board has the right to terminate any assistance granted if any information provided in this application is not accurate, if I do not meet eligibility requirements, or if I fail to provide information requested.

____ I understand that any financial assistance approved will be paid directly on the specific bill or to the creditor, and not in the form of a direct cash payment, or reimbursement, to me. Further, I must provide a copy of any bill to be paid in advance of its due date and past due bills should not be submitted.

____ I understand that in no event shall The Cancer Gala Board be liable in any way for damages alleged to result from errors or delays in the processing of the applications or grants awarded, or issuance of payments as part of the program, or resulting from use of any funds awarded. I release The Cancer Gala Board of any and all liabilities arising out of any donation of money provided to me or on my behalf.

By signing below, I attest that I have read, fully understand and agree to the above Attestation and my Application for Financial Assistance and I authorize The Cancer Gala Board to obtain from the individuals, businesses, organizations, agencies or entities listed in this application whatever information is necessary about my case that might be helpful for assessing or verifying my application.

Applicant Signature:_____ Date:_____