Health Statement

*(To be completed by a medical team member who is familiar with the patient’s cancer treatment, certifying patient is currently undergoing cancer treatment.)*

**Patient Information**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Cancer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Monthly Cancer Treatment Visits\_\_\_\_\_\_\_\_\_

Anticipated Length of Treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Grant Information**

I recommend the patient apply for the following grants: transportation (gas)\*  oral medication\*  housing payment\*  car payment\*  medical expenses\*  medical supplies\*

Provider Representative Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ I understand that Heartland Cancer Foundation will request only that information needed to process and administer this application. We will not disclose the information obtained except as needed for this purpose or as required by applicable law. I hereby represent, covenant and certify that as follows that the information contained in this application is complete and accurate to the best of my knowledge. Heartland Cancer Foundation may revise, change, or terminate the grant at any time.

\*Supportive Documentation for Grant Information must be attached to this document for approval.

Mail to: Heartland Cancer Foundation, P.O. Box 5203 Lincoln, NE 68505

**Heartland Cancer Foundation**

P.O. Box 5203 Lincoln, NE 68505. 402-261-9974. HeartlandCancerFoundation@gmail.com. www.HeartlandCancerFoundation.org