



P.O. Box 8832
Ketchikan, AK 99901
(907) 225-4104

APPLICATION FOR ASSISTANCE

Name _____ Phone _____

Address _____ City _____ Zip Code _____

Birth Date _____ SSN _____

Physician _____

Diagnosis _____

Assistance may be requested every 6 months.

- ✿ **Initial request/award:**
 - Up to \$2,000 maximum
- ✿ **Subsequent requests/awards:**
 - Will be reviewed and met as funds allow.

Maximum benefit period is 3 years from the date of the initial request.

ASSISTANCE REQUESTED:

A. Financial Assistance for Medical Treatment or Travel

Please describe what is needed – medication, specialized treatments, travel, lodging, etc.

We are only able to reimburse for documented expenses and will need receipts for our records. Please note: Only the following expenses will be covered; travel, lodging, car rental (if indicated), and any medical bills not covered by insurance.

(Note: If travel assistance is requested, please state whether this treatment is available locally and, if so, your reason for leaving. Second and Subsequent **NON-EMERGENT** Travel Grants will be limited to the cost of a Super-Saver ticket.

B. Financial Assistance for Screening Exams

Please state what type of screening exam is required.

Signature _____ Date _____

✿ FCCC Use Only					
\$ Receipts	Date Pd.	Amount Pd.	\$ Receipts	Date Pd.	Amount Pd.

