



CRA

CANCER RESOURCE ALLIANCE

SUPPORTING RESIDENTS OF
MONTEZUMA AND DOLORES COUNTIES

Application for Financial Assistance

Name: _____ DOB: _____

Mailing address: _____

Physical address: _____

Email address: _____

Home phone: _____ Cell phone: _____

Who referred you to our group? _____

Cancer type: _____

Date treatment/testing began or will start: _____

Have you received funds from the Cancer Resource Alliance in the past?

Yes No

In order to receive financial assistance please attach a physician's statement of cancer diagnosis or testing.

This application may be downloaded at www.cancerresourcealliance.org and mailed to:
Cancer Resource Alliance, P.O. Box 569, Cortez, CO 81321

For questions, please call Sue at 970-759-9623.

(Please note, amount of financial assistance granted is subject to the availability of funds.)

Signature: _____ Date: _____

