6069 S. Fort Apache Rd. Suite 100, Las Vegas, NV. 89148
Phone: 1-888-252-8866 **Fax:** 702-410-2601
Email: info@scrnet.org **Web:** www.scnet.org

APPLICATION FOR ONE-TIME GRANT

PATIENT INFORMATION (please print)
First name: _______________________ Last name: ________________________
Today's date: _______________
Address: ______________________________City:_______________ State:__________ Zip: __________
Phone number: Home ( ) ________________________ Work ( ) _________________________
Cell ( ) ______________________ Email address _______________________________
Date of Birth: ____________ If patient is a minor (under 18), name of parent or guardian:_____________________
❑Male ❑Female Ethnicity: ❑White ❑African American ❑Latino ❑Asian ❑Other __________
Name of person completing this section (please print):
First name: _______________________ Last name: ________________________
Signature: _______________________________________ Date: _________________________________
Relationship to person applying for grant: ❑Self ❑Spouse ❑Family Member/Caregiver ❑Health Care Professional

MEDICAL INFORMATION (Must be completed by nurse, doctor, or social worker ONLY.)
Date of diagnosis: ____________ Primary cancer: __________________ Stage _______
❑New Diagnosis ❑Recurrence **Is patient in active treatment? ❑Yes ❑No**
If not in active treatment, indicate frequency of follow-up: ❑Yearly ❑Every Six Months ❑Other_________
Please indicate type of treatment(s) received in past twelve months (check all that apply)
❑Chemotherapy ❑Radiation ❑Surgery ❑Palliative Care
HEALTH CARE PROFESSIONAL INFORMATION (please print):
MD name: ______________________________ Hospital/Clinic: ________________________________
Address: ______________________________________ City, State, Zip: _________________________
Phone: ( ) ______________________ Fax: ( ) ______________________
NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):
____
Phone: ( ) _______________________ Email: ____
Your relationship to person applying for help: ❑Doctor ❑Nurse ❑Social Worker
Signature of MEDICAL PROFESSIONAL: ________________________________
Date: ____________

THANK YOU.
Fax this form to (702) 410-2601 or mail to: Stomach Cancer Relief Network Inc., 6069 S. Fort Apache Rd. Suite 100, Las Vegas, NV. 89148
Please be aware that funds are limited and based on availability.
Stomach Cancer Relief Network Inc. will review this information.
All information is strictly confidential and is for Stomach Cancer Relief Network use only.