



6069 S. Fort Apache Rd. Suite 115, Las Vegas, NV. 89148
Phone: 1-888-252-8866 Fax: 702-410-2623
Email: info@scmnet.org Web: www.scmnet.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) 410-2623 or mail to: Stomach Cancer Relief Network Inc., 6069 S. Fort Apache Rd. Suite 115, Las Vegas, NV. 89148

Please be aware that funds are limited and based on availability.

Stomach Cancer Relief Network Inc. will review this information and contact the person requesting financial assistance.

All information is strictly confidential and is for Stomach Cancer Relief Network use only.

