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office use only

NEW HOPE FOR CANCER – DEUEL COUNTY
Application for Cancer Related Assistance

Per this form, I request financial assistance related to my cancer diagnosis.
(*type of cancer*: _____)

Name: *(please print)* _____

Address: _____
**(To be approved, this address confirms my residence is in Deuel County, SD.)*

Please submit a current copy of your pathology report or a statement of diagnosis from your physician.

- I understand that, if my application is approved, New Hope for Cancer will grant me $1,000 over a one-year period, beginning September 1st through August 31st.

- Financial assistance will be paid to me via check from New Hope for Cancer *doing business as Deuel County Charities.*

- I understand that, as needed, New Hope for Cancer has the right to request further information from me to approve my application.

- **All information I have provided in this Application will be kept confidential, known only to the designated board member(s) who receive, process and award financial assistance. This follows the guidelines set by New Hope for Cancer.**

Signature of Applicant _____Date:_____

Mail this application to:

New Hope for Cancer
PO Box 72
Clear Lake, SD 57226