CASE #_____

DEUEL COUNTY CHARITIES, INC—NEW HOPE FOR CANCER
APPLICATION FOR CANCER RELATED ASSISTANCE

I hereby request financial assistance as I am ill with _____cancer.
(kind of cancer)

NAME: (please print)_____

ADDRESS:_____

I have been a resident of Deuel County since_____.

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 in whole, or part, the Deuel County Charities, Inc. will grant me a minimum of $1,000 over a one-year period, beginning September 1st through August 31st.
- It will be paid to me in the form of a check from Deuel County Charities, Inc.
- Attention will be given to your request upon receipt of application and you will be
- notified by mail regarding the decision of Deuel County Charities, Inc. representatives.
- A new request is needed at the beginning of each year. (Sept 1st to Aug 31st)
- All applicants need to be a resident of Deuel County, South Dakota.
- Deuel County Charities, Inc. has the right to request further information if needed for verification.

SIGNATURE OF APPLICANT _____
(Parent or legal guardian signature required if applicant is under the age of 18)

DATE_____

Mail this application to: **Deuel County Charities, Inc.**
New Hope for Cancer
P O Box 72
Clear lake, SD 57226

Client notified of action _____