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 Canon City, CO 81212
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E Mail: fremont@orchardofhope.org
 E-Mail: pueblo@orchardofhope.org
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APPLICATION FOR ASSISTANCE

Please provide the following contact information:

Name: _____

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____

Date of Birth _____

Please complete the following:

Diagnosis: _____

Physician: _____

1. Medical documentation of cancer and treatment for cancer within a year of the date on which you are applying, from your doctor or treatment center.
2. Copies of bills for us to pay or receipts for reimbursement for expenses incurred during your cancer treatment.
3. Copy of your driver's license or proof of residency, library card, utility bill in your name, etc.
4. You must have been a resident of Fremont or Pueblo County at least 6 months or funding will be prorated accordingly.

Please tell us what you are applying for and treatment you are receiving. _____

Have you received assistance from us before?

I hereby authorize

_____ at _____

Name of health facility or Dr.

Telephone

to exchange my health information. I understand that this may be transmitted by fax. I hereby release the Orchard of Hope Foundation from any liability resulting from the release of information.

Signature _____ Date _____

Referred by: _____:

May we use your name in a press release? _____ Yes _____ No

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED FOR FUNDING.