GRANT APPLICATION GUIDELINES
FOR INDIVIDUALS/FAMILIES

YOUR MEDICAL FACILITY WILL BE CONTACTED TO VERIFY THE TREATMENT OF NOTED CANCER PATIENT AS WELL AS OTHER ORGANIZATIONS INVOLVED WITH YOUR APPLICATION. PLEASE SIGN THIS FORM ACKNOWLEDGING YOUR APPROVAL FOR THE WE CARE ENDOWMENT.

PATIENT'S SIGNATURE ____
Authorizes release of medical information

DATE OF SIGNATURE ____

Description of each purpose for the use or release of the information [45 C.F.R 164.508 (c) (iv)]

This information will be used for the sole purpose of evaluation the above patient for support services offered by the We Care Endowment. This HIPAA releases is valid for a 180-day period from the patient's signature date shown above and only if signed by both the patient and oncologist's office.

REQUESTS CAN BE MAILED OR DELIVERED TO:
WE CARE ENDOWMENT
P.O. BOX 21832
LINCOLN, NE 68542