



Rock County Cancer Coalition Application Instructions

Applicant Name _____ **Date** _____

ALL 5 PAGES MUST BE COMPLETED AND INCLUDED TO BE CONSIDERED FOR A GRANT

Reminder: you must be in active treatment for your application to be considered.

1. _____ **COPY OF CURRENT DRIVER’S LICENSE OR STATE ID:** Provide a copy of your current driver’s license or state identification card for proof of residency
2. _____ **COPIES OF BILLS/EXPENSES:** Include a copy of each bill you are asking for assistance with. The address on the bill must match the address on your driver's license/ID
3. _____ **REQUEST FOR ASSISTANCE FORM**
4. _____ **DIAGNOSIS VERIFICATION FORM and TREATMENT STANDARD FORM**
Give this to your doctor to complete and sign.
5. _____ **AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**
6. _____ **RCCC SIGNED APPLICATION**
7. _____ **ALL 5 PAGES, COPIES OF BILLS AND COPY OF DRIVER'S LICENSE**

Rock County Cancer Coalition PO Box 2092 Janesville, WI 53547
For any questions, please call RCCC at 608-754-2286 or Email: Info@Rockcountycancercoalition.org

Last Updated 03/08/2023

FOR OFFICE USE ONLY

CASE #	DATE	
DESCRIPTION OF SUPPORT	CHECK #	AMOUNT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____