FAITH
"Fighting Cancer"
IN MONTGOMERY COUNTY

Assistance Request Program

FAITH "Fighting Cancer" is organized exclusively for charitable, scientific and educational purposes. We are a 501(c)(3) nonprofit, run without any paid staff and not affiliated with any religious denomination or other organization. Our mission is to provide emotional or financial support to cancer patients and their families as well as assist in educational and preventative care programs in the Montgomery County area with the generous donations of businesses, individuals and active fund raising volunteers

To apply and qualify for review you must meet only 3 simple requirements:

- The patient is currently receiving cancer treatment.
- The patient reside in Montgomery County Texas or the surrounding area
- Complete the attached application in full and return

All applications are reviewed and the extent if any assistance is a board decision.

A volunteer will be assigned to you and you will be notified if we can provide any or your entire request.

We are a small organization and our funds are limited, but assisting patients with Cancer in MontgomeryCounty is our highest priority.

Please mail the application to the address below and contact us if you have any questions.

Barbara: hilton@consolidated.net 713 725 7070
Maggie: mmm.maggie@ymail.com 936 443 8527

Sincerely,

The Board of Directors
FAITH "Fighting Cancer" in Montgomery County

FAITH Fighting Cancer in Montgomery County
P.O. Box 445
Conroe, Texas 77305
faithfightingcancer@gmail.com • www.faithfightingcancermc.org

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Patients Name _____ Age & Sex _____

Address City St Zip_____

Contact's Phone: home _____ cell _____ work _____

Best time to call _____

E-mail address _____

Spouse, Parents or Guardian _____

Child Age/Sex _____

Child Age/Sex _____

Child Age/Sex _____

Child Age/Sex _____

If there are additional family members, please add on a separate page.

We recognize that not every family has the same needs, so please describe in your own words what would help you or your family the most—for example: medical supplies, transportation assistance, food, personal items, or other request.

_____

_____

_____

We respect your family's privacy, but please answer a few more questions.

Type of Cancer: _____ When Diagnosed: _____

Location of treatment: _____

Doctor or religious affiliate's name and number who we may contact for verification:

_____

Signature below indicates authorization to contact and release or confirm information

Name: _____

Phone number: _____E-mail: _____

Patient/Parent/Guardian Signature:_____Date _____

Person submitting application (if other than above) _____

Best phone #/time to call: _____

E-mail _____

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