FAITH
"Fighting Cancer"
IN MONTGOMERY COUNTY

Christmas Assistance Program

FAITH "Fighting Cancer" is organized exclusively for charitable, scientific and educational purposes. We are a 501(c)(3) nonprofit organization, 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 the educational and preventative care programs in the Montgomery County area. We rely on generous donations from businesses, individuals, and active fundraising volunteers.

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

- The patient is currently receiving cancer treatment.
- The patient resides in Montgomery County, Texas, or surrounding area.
- The application must be completed in full and returned to FAITH.

All applications are reviewed. The extent of assistance, if any, is a decision of the Board of Directors. A volunteer will be assigned to you, and you will be notified if we can help you with some or all of your request. We are a small organization with limited funds, but our highest priority is assisting patients with cancer in Montgomery County.

Please mail/e-mail the application to the address below. Contact us with 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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Patient's Name _____ Age & Sex _____

Spouse (if applicable) Name & Age _____

Total Number of Family Members _____

Address _____

Contact's Phone: home _____ cell _____ work _____

Best time to call _____

E-mail address _____

We recognize that not every family has the same needs, so please describe in your own words what wouldhelp 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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