QUAPAW NATION
CANCER AWARENESS COMMITTEE

ASSISTANCE APPLICATION

Applicant Information

Full Name: _____ **DOB**: _____
Last ***First*** ***M.I.***

Address: _____
Street Address ***Apartment/Unit #***

_____
City ***State*** ***ZIP Code***

Phone: _____ **Email**: _____

Questionnaire

Are you currently receiving treatment for a cancer diagnosis? _____

Have you received assistance from this committee since 1/1/2021?
If so date: _____

If a minor, please list parents name(s): _____

Are you a member or employee of the Quapaw Nation? _____

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ **Date**: _____

GUIDELINES

1. Must be either a Quapaw tribal member or employee of the Quapaw Nation.
2. Currently receiving treatment for cancer.
3. Must not have received funds since 1/1/2021.
4. Can only receive funds once every three (3) years.
5. Doctors statement of diagnosis required. See the attached Physicians Statement.

PHYSICIANS STATEMENT

_____ is currently receiving treatment for a diagnosis of cancer.
(Applicant Name)

Physician Name: _____

Physician Contact information: _____

Physician Signature: _____