CANCER PREVENTION & RESEARCH INSTITUTE OF TEXAS

Texans Conquer Cancer

Patient Support Services Application (2010)

(1) Applicant/Organization:					
(2) Mailing Address:					
(3) City, State & Zip:					
E-mail:			Telephone: ( )		
(4) Texas or Federal Vendor ID #:			Non-Profit Charter #:		
(5) Confidentiality: Check if a system is in place to protect client and patient records from inappropriate disclosure. ☐					
(6) Agency Contract Official:					
Name:			E-Mail:		
Title:					
Address:					
Signature:			Telephone: ( )		
(7) Financial Information, Fiscal Year:					
Time Period					
CPRIT Funding Begin Date	to	CPRIT Funding End Date	CPRIT Request $	Contributions In-Kind $	Project Total Cost $
M D Y		M D Y			
8) Fiscal Contact			Telephone: ( )	Fax: ( )	
Address:			E-mail Address:		
(9) Cancer support services to be provided with these funds:					
(10) Services are provided to a cancer patient and/or caregiver of cancer patient:				Yes	No
(11) Number of people to be served with program funds:					
(12) Cost per person served:					
(13) Justification of need:					
14) Experience providing cancer support services:					