



- ◇ The Havre Women's Golf Association Assistance Fund was created to provide assistance to individuals who reside on the Hi-Line who have an active Cancer Diagnosis.
- ◇ This fund is financed solely by the proceeds of the annual golf tournament. The total available assistance each year is limited by those totals.
- ◇ The assistance is available to be used however the individual sees fit.
- ◇ There is a \$500 maximum available per person per calendar year.
- ◇ In order to avoid duplication of funding sources, each case is reviewed individually.
- ◇ The application may be completed by the patient or by an immediate family member.



Northern Montana Health Care Foundation  
PO Box 1231  
Havre, MT 59501

Havre Women's  
Golf Association  
Assistance Fund



# Application

## **Havre Women's Golf Association Assistance Fund Application**

Patient's full name \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian/Applicant Names \_\_\_\_\_

Physical Address \_\_\_\_\_

Street Name \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address \_\_\_\_\_

Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Parent/Guardian Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Nature of Illness \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use additional sheet of paper if necessary)

Have you received assistance from this fund in the past Yes No

If so, provide date/s and amount/s received: \_\_\_\_\_

***Allocation of funds is administered  
by the Northern Montana Health Care Foundation.***

**Please attach written documentation from physician verifying your diagnosis.**

I certify that the information provided is true and correct to the best of my knowledge and that I am not requesting financial assistance from any other organization at this time.

Signature of Patient, Parent, or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### **Send Application to:**

Havre Women's Golf Association Assistance Fund

c/o Northern Montana Health Care Foundation

PO Box 1231

Havre, MT 59501

Application and supporting documentation may  
also be faxed in to (406) 262-1629.

### **FOUNDATION USE ONLY:**

Approved by: \_\_\_\_\_

Calculators: \_\_\_\_\_

\_\_\_\_\_

Amount: \_\_\_\_\_

Check No. \_\_\_\_\_ Date: \_\_\_\_\_