



Date _____

Dear _____ ,

Our organization was formed for the sole purpose of extending a helping hand to cancer patients throughout Marquette County who need financial assistance. Our mission is to provide help with expenses directly related to treatment including travel to care. You need not be low income to apply for assistance. As it is necessary for us to be good stewards of the funds we have available in order to help as many patients as possible, our Board of Directors asks your cooperation with the following guidelines to receive assistance.

1. Please complete the enclosed application and return it to one of the patient care coordinators. We must be in receipt of the completed application before assistance can be provided. In addition to the requested demographic information, be sure to sign and date the form. This will enable us to communicate with billing entities as well as other assistance from programs we believe could help you as well.
2. In order to maximize the effect of our available resources, we can work with you to ensure that your insurance coverage and any other charitable or government benefits have been adequately explored.
3. In order to receive reimbursement for travel expenses, we require receipts for lodging, fuel, parking/bridge tolls and meals. We may be able to assist you in finding reduced rates at some cancer centers in order to conserve the funds we have available to you and might suggest you consider preparing your own meals where possible for extended stays.

If you have any questions or if emergent situations arise requiring immediate assistance, please feel free to contact the patient care coordinator through whatever means is most convenient for you. We look forward to providing assistance to help you and your family through this difficult time.

Sincerely,

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