Dear Patient/Guarantor:

Thank you for choosing Aspire Rural Health System for your health care needs. It is our mission and privilege to offer financial assistance to our patients to ensure quality of health for those we serve.

At your request, we have enclosed our P.C.U.P.S. program grant application. This grant provides $500 in financial assistance for those undergoing treatment for prostate cancer, and patients are eligible to reapply for funding every 6 months. Applicants must be a resident of Huron, Lapeer, Sanilac or Tuscola County.

In order for us to process your financial request, the following documents are required:

- **A completed application (enclosed);**
- **A copy of your state issued driver's license or identification card;**
- **A copy of documentation showing prostate cancer diagnosis.**

The completed application including all required documentation must be received for consideration.

Mail completed application and documentation to:

Aspire Rural Health System
Patient Accounting Department
ATTN: P.C.U.P.S. Program Grant
4675 Hill Street
Cass City, MI 48726

If you have any questions, please contact the Patient Accounting Department at 989-912-6800 Monday through Friday 8:00 a.m. – 4:30 p.m.

Respectfully,

Aspire Rural Health System
P.C.U.P.S. Program Committee

P.C.U.P.S PROGRAM GRANT APPLICATION

PATIENT INFORMATION

Patient Name: _____ **Birth Date:** _____

Marital Status: (circle): S M D W

Patient Address: _____
City/State/Zip Code: _____
County of Residence: _____
Primary Phone: _____ **Alternate Phone:** _____

PHYSICIAN INFORMATION

Physician Name: _____
Office Phone: _____ **Diagnosis:** _____

My signature on this form certifies that all statements are true to the best of my knowledge. I understand that this grant is limited to $500, but I can reapply for additional grant funding every 6 months while undergoing treatment for prostate cancer. I agree to allow Aspire Rural Health System or its representative to validate all information provided. I acknowledge and agree that the funds provided shall not be used for the purchase, consumption, distribution, or involvement with any illegal substances or any other unlawful activities. I understand that misuse of these funds may result in legal consequences and/or forfeiture of support.

PLEASE SIGN BELOW:

_____

Print Patient Name / Guardian **DATE**

_____

Signature Patient / Guardian **DATE**