



# CancerCare® Co-Payment Assistance Foundation

## Thank You For Supporting CancerCare's Co-Payment Foundation Fund

**CANCER CHANGES EVERYTHING. CANCERCARE® CAN HELP.**

Please print, complete, and mail this form with your check or credit card information to the following address: **CancerCare National Office | 275 Seventh Avenue, New York, NY 10001 | 212-712-8400**

First Name\* \_\_\_\_\_ Last Name\* \_\_\_\_\_

Address\* \_\_\_\_\_

City\* \_\_\_\_\_ State/Province\* \_\_\_\_\_ ZIP\* \_\_\_\_\_

Country \_\_\_\_\_ Email\* \_\_\_\_\_

I am making a one time gift of (select amount):

\$50       \$250       \$1,000       Other \$ \_\_\_\_\_

\$100       \$500       \$5,000

Specific Fund \_\_\_\_\_

**Make check payable to CancerCare.**

**To make your gift by credit card, fill out the information below:**

Name (as it appears on card) \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Expiration Date (MM/YY) \_\_\_\_\_

Credit Card (select one):

MasterCard     VISA     American Express     Discover

I authorize CancerCare to charge my credit card for the amount indicated above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

This gift is:     in honor of     in memory of

Name \_\_\_\_\_

Send card to (Name) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State/Province \_\_\_\_\_ ZIP \_\_\_\_\_

Country \_\_\_\_\_ Email \_\_\_\_\_

\* Asterisks indicate required information.