Southwest Health System Foundation – Cancer Grant Application

The Southwest Health System Foundation provides annual Cancer Grants for residents of Montezuma and Dolores Individual grants may be up to $1,000 to assist with transportation, living expenses, travel, or related needs during treatment. Applications must be received by June 1 for consideration in the current year's award cycle.

Key Dates

- Application deadline: June 1 (11:59 PM). Applications received after June 1 roll into next year's cycle.
- Fundraising cutoff: Donations made after June 1 count toward the next cycle.
- Notification & awards: Successful applicants are notified after Board approval (summer). You will be notified of application receipt by the email provided.

Submission Instructions

Please complete and submit this form by mail to: PO Box 1585, Cortez, CO 81321
OR email to: info@swmhfoundation.org
Applications received after June 1 will be considered for the following year.

Privacy & Assistance

All information provided will be kept strictly confidential and used only to evaluate your application and administer grant funding. If you need help completing the application or require language support, please contact us. We're happy to assist.

Optional Consent

☐ I consent to being contacted to share an optional impact story that may be featured in Foundation materials.

Southwest Memorial Hospital Foundation

Montelores Cancer Care Assistance Grant

Individual Montezuma Cancer Care Assistance Grants are offered by the Southwest Memorial Hospital Foundation to residents within the service area who have been diagnosed with cancer.
Grants of up to $1,000 are intended to help patients and families with expenses related to treatment, including transportation, travel, living costs, and other essential needs.
Please submit your completed application to: PO Box 1585, Cortez, CO 81321
Applications must be received by June 1 for consideration in the current year's award cycle.

Assistance Grant Application

Date: _____

Name: _____Relationship to patient: _____

Address: _____

Home phone: _____Cell phone: _____

E-mail: _____Alternate contact: _____

Medical Condition: _____

_____

_____

_____

Patient's Physician (s): _____

Need for assistance (describe): _____

_____

_____

Other information: _____

_____

_____

Applicant signature: _____

Physician verification:

Name: _____Signature: _____Date: _____

Staff Use Only

Receipts submitted: _____