Genevieve's Helping Hands, Inc.
resources for young women with breast cancer

THE GENEVIEVE MEMORIAL GRANT GUIDELINES

This grant is established in the memory of Genevieve Sounia, a young mother who died of breast cancer. During her treatment she was able to take a short time away from home to recuperate from some of the procedures. Genevieve considered it a blessing and felt it improved her recovery. Because this option is not easily available to all patients, The Grant was created to provide this opportunity to other young mothers fighting breast cancer. Its' intent is to support treatment and enhance recovery from breast cancer and breast cancer related treatments.

Criteria of the Grant:

- For young mothers first diagnosed with breast cancer at age 40 or younger.
- For young mothers starting breast cancer treatment, in treatment, or recovering from treatment.
- To be applied at mutually agreed upon dates and a location outside of the home.

Provisions of the Grant

- Genevieve's Helping Hands, Inc. will arrange and pay for a mutually agreed upon location to apply the grant, for example, staying at a hotel.
- Grant period will cover up to a three night stay for the recipient, one caretaker, and a stipend for meals and other necessities. Examples include hotel, meals, taxi to/from treatment center.
- Genevieve's Helping Hands, Inc. will assume responsibility only for arranging and paying for the bills associated with the agreed upon location and other stipulations of the grant.
- Changes in dates can be made due to unforeseen changes.

Process of the Grant

- Applications will be reviewed by the Grant Committee. Based on their review, they will make recommendations to the Board of Directors, who will vote to award the grant.
- The application process includes an interview. During the interview, the applicant will have an opportunity to explain her need and intended use of the grant, including approximate dates, location, and any extenuating circumstances.
- After approving the grant recipient, Genevieve's Helping Hands, Inc. will make the arrangements and pay for them directly to the mutually agreed upon location and time, and will provide the stipend in the form of a gift card.
- Send completed application to:

Genevieve's Helping Hands, Inc.
c/o Anne Rickmeyer
263 Division Ave
Hicksville, N.Y. 11801 or
e-mail to: mail@genshelpinghands.org – Subject: Grant Application
Questions? Call 516-500-3702

Revised 05/04/2015

Application for The Genevieve Memorial Grant

Grant Criteria

For young mothers first diagnosed with breast cancer at age 40 or younger
For young mothers starting breast cancer treatment, in treatment, or recovering from treatment
To be applied at mutually agreed upon dates and a location arranged by Genevieve's Helping Hands, Inc.

Date: ______________ Name: ____

Address: ____ Home Tele No. __________________

Cell Phone:_______________ Additional Contact:________________E-mail: ________________________

Diagnosis: ____

When diagnosed: ___________________________ Age at first diagnosis: ______________

Type of treatment(s):____

Date of treatment(s): _________________________Start Date of Grant: _____________________________

Location of treatment(s): ____

In what city/state do you want this grant applied? ____

When are you available for a phone interview? Dates: ____________________ Times: _________________

On a separate sheet please provide any additional information that you feel is important to help us better understand your need for this grant. Include the following: family income, number of children living in the home, their ages, and expected days in hospital. Also include any extenuating family situations, for example: caring for adults, other medical situations, military status, etc.

Can we share your name only when we announce awarding a grant? ___________

I affirm that all information is correct. I understand that Genevieve's Helping Hands, Inc. is not a healthcare provider, and therefore the information released is not protected by federal privacy protections.

Signature ____

Send Application to:
Genevieve's Helping Hands, Inc. c/o Rickmeyer
263 Division Ave
Hicksville, N.Y. 11801 or
e-mail to: mail@genshelpinghands.org – Subject: Grant Application
Questions? Call 516-500-3702

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Medical Verification

To be completed by a member of the
Patient's Medical Team

Date: ___________________________

Name of Patient: ____

Home Address of Patient: ____

Date(s) of Treatment(s): __________________________________

Type of Treatment(s): ____

Location of Treatment(s): ____

If applicable, recommended optimal recovery time outside of the hospital:
____

Your Name and Title: ____

Address: ____________________________________Tel. Number: _______________

E-mail: ____________________________________

Comments: (Optional) ____

____

Signature: ____ Date: _______________

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