



Genevieve's Helping Hands, Inc.

supporting young women with breast cancer



Application for The Genevieve Memorial Breast Cancer Recovery Grant

Medical Verification

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

Date of Medical Verification: _____

Patient's Name: _____

Patient's Address: _____

Street 2 _____

City _____ State _____ Zip _____

Diagnosis (type, stage, etc) _____

Date(s) of Treatment(s) _____

(Months /Year)

Type of Treatment(s): _____

Treatment Facility: _____ Location: _____
City / State

Physician's Name (Provider): _____ Title: _____

Member of team completing form: _____ Title: _____

Member of Medical Team E-Mail: _____

Facility Address:

street _____

Street 2 _____

City _____ State _____ Zip _____

Facility Telephone: _____

Comment: (Optional) _____

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

Signature: _____

Date: _____

Grant Criteria

For mothers first diagnosed with breast cancer at age 40 or younger
Associated with recovery from breast cancer treatment
To be applied at mutually agreed upon dates and a location arranged by
Genevieve's Helping Hands, Inc.
Genevieve's Helping Hands will pay for Grant location and related expenses.