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: _____ Date of Birth: mo ____ day___ year_____

Patient's Address: _____

Street _____

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.