



Genevieve's Helping Hands, Inc.

supporting young women with breast cancer



Application for The Genevieve Memorial Breast Cancer Recovery Grant

Personal Information

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.

Date of Application: _____

Patient's Name: _____

Patient's Address: _____

Street 2 _____

City _____ State _____ Zip _____

Phone Number: _____ Cell Phone Number: _____

E-Mail Address: _____

Additional Contact: _____ Phone Number: _____

Diagnosis (type, stage, etc.): _____

Family Situation (including ages of children): _____

Past Surgery / Treatment: _____

Current Surgery / Treatment: _____

Treatment to which grant will be applied: _____

Date of Surgery / Treatment: _____

Location of Treatment: _____ City: _____ State: _____

Dates Grant will be used: Start Date: _____ End Date: _____

Location where Grant would be used: _____ ++++++++ _____

When are you available for a phone interview: _____

Please provide any additional information that you feel would help us better understand your need for this grant: _____

How did you hear about this grant opportunity: _____

Would you allow us to share your name upon receiving a grant (i.e. Facebook etc.): _____

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: _____