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

e-mail to: mail@genshelpinghands.org – Subject: Grant Application
Questions? Call 516-500-3702

Revised 05/04/2015
**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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