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: _____ Date of Birth: mo ____ day___ year_____

Patient's Address: _____

Street 2 _____

City _____State _____ Zip _____

Phone Number: (____)_____ Cell Phone Number: (____)_____

E-Mail Address: _____

Additional Contact: _____Phone Number:_____

Date of Diagnosis: mo ____ year _____ Age at Diagnosis: _____

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: _____