Assistance Application

Application Name_____ Phone: _____

Applicant address: _____City: _____State: ____
Zip code:_____

Applicant personal email: _____

Attending Physician Name: (*please print*) _____

Assistance Requested for: (*list bills and provide copies*)

1)_____ Amount $_____

2)_____ Amount $_____

TOTAL $_____

Applicant Signature: _____Date_____

Attending Physician USE ONLY

I confirm that the above-named applicant: (check appropriate box)

_____Cancer diagnosed Date: _____

_____Currently in ACTIVE treatment for cancer (chemotherapy or radiation)

Physician's Signature:_____Date_____

Thriving & Surviving Breast Cancer Support Group Inc. Application Process:

- Membership in Thriving & Surviving Support Grp Inc. is not required for consideration.
- Application MUST be signed by attending physician to be considered.
- Include supporting documents: Current bills/receipts with application.
- Please allow 10-15 business days for application decision.
- Financial Assistance is subject to funds available.
- Upon approval, checks will be sent to the applicant, payable to the service provider.
- Applicants can only apply once within a 12-month period.
- Assistance can be up to $250 per 12-month period, per the board's discretion.