



Fund for Women Cancer Care Grant

*This fund is dedicated to assist girls and women who currently have cancer and are experiencing financial hardship with associated expenses not covered by insurance. Examples of these challenges include: wigs, head coverings, barriers to making appointments such as child care and transportation costs, nutrition, etc. Patients must reside in **Chemung, Schuyler, Steuben, or Yates counties**. The maximum grant is \$500 per calendar year.*

ID: _____ for office use only

Name _____

Mailing Address _____

City/State/Zip _____

County of Residence _____ **Must reside in Chemung, Schuyler, Steuben, or Yates County**

Phone Number _____ Email _____

Age _____ Gender _____

If patient is under 18, name of parent or guardian _____

MEDICAL INFORMATION : Primary Cancer _____ Treatment Center _____

Social Worker/Financial Advocate Name _____ Phone _____

AMOUNT BEING REQUESTED \$ _____ (may not exceed \$500)

Have you previously received a Fund for Women grant? _____ No _____ Yes If yes, when _____

What type of grant did you receive?

- Fund for Women Cancer Care Grant Fund for Women Education Grant

FINANCIAL NEED: Please indicate any financial need or unusual family/personal circumstances you feel may warrant attention. (i.e., loss of employment, financial hardships, financially dependent children, single income, etc.)

Please include a brief description of what the grant funds will be used for.

How did you hear about this grant opportunity?

The information submitted is held in strictest confidence, is only seen by the staff at the Community Foundation and shredded after a determination has been made. ****I ATTEST BY WAY OF MY SIGNATURE THAT ANY FINANCIAL ASSISTANCE GRANTS WHICH MAY BE AWARDED WILL BE UTILIZED FOR THE EXPENSES INDICATED ABOVE****

Signature _____ Date _____

Parent/Guardian if applicant is under 18 _____