PO Box 23841, Rochester, NY 14692 Phone/Text: 585-825-9334 Email: contact.helpsis@gmail.com

Applicant Information

Name		
Date of Birth		Age
Address		
City		State
Zip code		
Home/Cell Phone		
Email		

Household

Marital Status (circle one)	Single	Married
	Divorced/ Separated	Widowed
Number of People living in household (including applicant)		
Name		
Relationship		Age
Name		
Relationship		Age
Name		
Relationship		Age
Name		
Relationship		Age

Describe how your current diagnosis & treatment of breast cancer is affecting your financial need. *Required

SIS may require additional financial information for decision to provide assistance.

Please explain what specifically you are requesting*REQUIRED

Authorization of Release of Information/Notice of Privacy

By signing this release, you hereby authorize Sustain, Inspire, Survive (SIS), without reservation that I hereby give permission for SIS to contact any party for information directly related to this grant application in the interest of SIS making a decision to approve or deny the financial grant for assistance. SIS will demonstrate respect for the following patient needs: confidentiality; privacy, and security of this application. Records and information are protected against Loss, destruction, tampering and unauthorized access or use.

Signature		**Date**

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Employment & Insurance

Applicant's Employer		
Are you currently employed?	Yes	No
Do you have health Insurance?	Yes	No
Provider or Medicaid/Medicare		

Income Sources

Applicant's Monthly Income	$	
Spouse's/ Partner's Monthly Income	$	
Alimony/ Child Support	$	
SSI/ Disability	$	
Unemployment	$	
Pension/ Retirement	$	
Workers Compensation	$	
Veteran's Benefit	$	
Food Stamps (SNAP)	$	
Other Income	$	
Are you receiving funds/ loans/ donations from any other agency?	Yes	No
If yes, please list	$	
	$	
	$	
Total Monthly Income	$	

Total Monthly Income	$	
Total Monthly Expenses	$	
Monthly Income minus Monthly Expenses	$	

Resources *Required

Personal/Joint Checking Account Balance	$	
Savings Account Balance	S	
Retirement Accounts	S	
Home equity/ other real estate	S	
Other Resources	S	
Total Resources	S	

Monthly Expenses

Rent/ Mortgage	$	
Gas/ Electric	$	
Water	$	
Phone	$	
Internet/Cable/Streaming	$	
Groceries	$	
Childcare	$	
Car Payment/Transportation Costs	$	
Monthly Health Insurance Premium	$	
Prescription Copays	$	
Monthly Medical Copays	$	
Monthly Student Loans	$	
Monthly Credit Card Debt	$	
List Other Liabilities/ Expenses	Yes	No
	$	
	$	
	$	
Total Monthly Expenses	$	

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Medical Information/Provider's Verification Form-REQUIRED FOR GRANT REVIEW

Patient's Name	
Patient's Date of Birth	
Physician Name (provide name of treating physician-please print)	
Physician's Phone Number	
Date of Diagnosis	
Diagnosis and Stage	
Beginning date of Active Treatment	
Treatment: Surgery _____ Chemo _____ Radiation Therapy: Date/Type_____	
Expected Treatment End Date:	
Specific physical limitations:	

Is patient medically cleared for employment? Yes_____ No_____

If yes, projected date to return to work _____

Additional Comments:

Provider Signature	
Date	