Patient Grant Application

Forever Pink Foundation's mission is to positively impact the Kearney and surrounding communities with focus, support, and resources needed to financially and emotionally assist those battling breast cancer.

Date: _____
Name: _____
Mailing Address: _____
Phone: _____
Email: _____
Birthdate: _____
Date of Diagnosis: _____
Description of Diagnosis (please include your stage or oncotype information): _____
_____
Current Average Monthly Income: _____
Are you currently actively employed? YES NO If YES, Where _____
Are you the sole income provider for the household? YES NO
Are you financially responsible for any minor children? YES NO
Are you currently in active treatment? YES NO
Have received assistance from any other organization in the last 3 months? YES NO

Please select category of assistance you are requesting:
(Please select only ONE category)
_____Housing (mortgage/rental; cap of (1,500)
_____Medical Bills (cap of $1,000)
_____Transportation (car payment, repair; cap of $750)
_____General Use Assistance (cap of $500)
_____Other (TBD) _____

You MUST include the following supporting documents with your application. Incomplete applications will not be considered:

_____ A letter from your oncologist or surgeon or nurse navigator that confirms your diagnosis of breast cancer.
_____ A personal letter that tells us about your current situation and diagnosis.

Signature_____

Please mail or email application to:

PO BOX 2543

Kearney, NE 68848

foreverpinkfoundation@yahoo.com

Applicants who receive assistance may reapply in one (1) year. Applicants who do not receive assistance may reapply after three (3) months.

For additional information or questions, please call 308.293.6025 or email foreverpinkfoundation@yahoo.com.

You will receive a confirmation of your application and timeline for review and notification.