Project Pink

Application for Assistance

Project Pink'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 and oncotype information):

_____

_____

_____

Current Average Household Monthly Income: _____

Are you currently actively employed? YES or NO If yes, where? _____

Are you the sole income provider for the house? YES or NO

Are you financially responsible for any minor children? YES or NO

Are you currently in active treatment? YES or NO

Have you received assistance from any other organization in the last 3 months?

Please select category (only ONE) of assistance you are requesting:

_____ 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 that confirms your diagnosis of breast cancer OR the first page of your pathology report.

_____ A personal letter that tells us about your current situation and diagnosis.

Please mail or email application to:

Project Pink, Attn: Review Committee, PO Box 54, Kearney, NE 68848; kearneypinkproject@yahoo.com

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

Applicants who receive assistance may reapply in one (1) year. Applicants who do not receive assistance may reapply.

For additional information or questions, please call 308-293-6025 or email kearneypinkproject@yahoo.com.

CONCRETE CARES NEBRASKA