Application for financial assistance Team Breast Friends Grant

Making a positive difference in lives impacted by breast cancer, bringing awareness through our efforts.

How Do I Apply? The first step is to answer all the questions below which will determine if you meet TBF guidelines. Once completed and you meet the guidelines, we will contact you regarding the award.

http://teambreastfriends.org

Team Breast Friends
PO Box 55
Iowa City, IA 52244

Date_____

Please print clearly - all information is required

Name _____ Gender: Female _____Male_____
Last First Middle

Address _____ Phone _____

City _____ Zip_____ County_____ E-mail _____

Date of last mammogram _____ Are you currently undergoing cancer treatment? No_____ Yes_____

Date Diagnosed _____ Treating Physician_____

Combined family income: $ _____ or $ _____ Number of dependents _____
Monthly Annual

Are you covered by health insurance, medicare, medicaid or Veteran status? Yes _____ No _____

Have you received any other financial assistance? Yes _____ No _____

If yes, please explain _____

Are you in need of financial support to obtain a mammogram; diagnostic testing (biopsy) or medical supplies for breast cancer.

No_____ Yes_____

Personal / financial difficulty explaining need for assistance (if any)

To complete this application, please provide a statement from your treating physician confirming that you are currently receiving treatment. Additionally, Team Breast Friends must have permission to verify this information if necessary. The statement should include your treatment plan and the physician's signature on official Health Center stationery.

Please mail the completed form to:
Team Breast Friends, PO Box 55, Iowa City, IA 52244

Guidelines

1. All candidates must be actively undergoing breast cancer treatment, provide verification of their diagnosis, and submit documentation of financial need upon request.
2. Must provide verification of a cancer diagnosis and may be required to provide documentation of your financial need.
3. Residing and receiving treatment within the Corridor.

The above information is to the best of my knowledge is true, factual and accurate. I understand it may be necessary to be called for further information.

By signing below I hereby consent to the use and disclosure of my personal and health information contained on this form by Team Breast Friends.

Applicant's signature_____ Date_____

Please print and sign the application form before mailing it to Team Breast Friends.
Private and confidential when completed.