Hope Chest for Breast Cancer Foundation

Grant Application

Patient Information

- First & Last Name: _____
- Phone Number: _____
- Primary Address (Please include number if applicable):

  _____
- City: _____ State: _____ Zip: _____
- County: _____
- Email Address: _____

Date of Birth: _____

Age Range – Check off the one that represents you

[ ] 18-24	[ ] 45-54
[ ] 25-34	[ ] 55-64
[ ] 35-44	[ ] 65 and over

Gender – Check off the one that represents you

[ ] Female	[ ] Transgender
[ ] Male	[ ] A gender not listed
[ ] Non-binary	[ ] Prefer not to say

Race/Ethnicity — Check off the one that represents you

[ ] Asian, Native Hawaiian, or Pacific Islander [ ] Non-Hispanic White

[ ] Native American or Native Alaskan [ ] White or Caucasian

[ ] Black or African American [ ] Two or More Races

[ ] Hispanic, Latina/o/x Spanish origin [ ] A race not listed

[ ] Middle Eastern or North African [ ] Prefer not to say

Hope Chest Grant History (Note: You are eligible to reapply every 12 months)

Have you received a grant from Hope Chest in the past 12 months?

[ ] Yes [ ] No If yes, approximately what date did you apply? _____

Metastatic or Stage 4 Disease

Do you have metastatic or Stage 4 disease?

[ ] Yes [ ] No [ ] Unsure

If you have metastatic or Stage 4 disease, is this a recurrent disease?

[ ] Yes [ ] No

Family Information & Financial Needs

Dependents: How many dependents are living in the home?

[ ] No Dependents [ ] 3 Dependents

[ ] 1 Dependent [ ] 4+ Dependents

[ ] 2 Dependents

Household Type

- Are you a single or dual-income household?

  Single-Income Dual-Income

- **Annual Household Income (Pick one)**

[ ] $100,001+ [ ] $50,001-$75,000 [ ] $0-$25,000

[ ] $75,001-$100,000 [ ] $25,001-$50,000

Treatment-Related Hardships (Please indicate any/all that apply)

[ ] Travel 2+ hours for hospital/clinic visits

[ ] Frequent clinic visits (2+ times/week)

[ ] One or more inpatient hospitalizations in the past 90 days

[ ] Immediate family member(s), who are uninsured and unemployed, have (or had) a serious chronic illness in the past 12 months

[ ] None of the above apply

Employment and Life Situation (Please indicate any/all that apply)

[ ] Patient earns primary income

[ ] Patient is on unpaid leave or unemployed

[ ] Patient is not currently receiving short-term disability

[ ] Other adults in home are on unpaid leave or unemployed

[ ] Patient does not have reliable transportation

[ ] Patient does not have stable housing

[ ] Patient does not have health insurance

[ ] None of the above apply

Additional Detail on Needs

- **Employment and Life Detail:** To help us understand your needs, please provide additional detail related to any boxes you checked in the Employment and Life section.
  _____
  _____
  _____
  _____

- **General Additional Information:** Please provide any additional information such as date of onset, treatment status, family dynamics, and economic situation (family or personal) that would be helpful to evaluate the application.

_____
_____
_____
_____

Hospital/Clinic Information

- Name of Primary Hospital and City Located:
  _____
- Name of Oncology/Radiation care facility: _____
- Name of Social Worker/Healthcare Provider: _____
- Email of Social Worker/Healthcare Provider: _____

Financial Support Request

Types of Expense or Bill Needing Payment (Required - Please check all that apply)

[ ] Mortgage Payment *

[ ] Rent Payment +

[ ] Utilities *

[ ] Transportation (Car Payment) *

[ ] Transportation (Gas Card)

[ ] Transportation (Uber Gift Card)

[ ] Childcare and or Adult Care +

[ ] Grocery (Gift Card)

[ ] Other – please list: _____

If there is an * or +, please submit documentation with this application or at the time of approval.

- *** Copy of the Bill:** Please make sure the account number and payment mailing address is listed and legible on the bill.
- **+ W-9 Requirement:** I understand that if I receive assistance in this category I will be required to provide a W-9 for that agency.

Please note we are unable to assist with medical or credit card bills.

Verification and Submission

Verification of Active Treatment

Hope Chest for Breast Cancer Foundation requires your provider to verify your treatment status. We will send an email to verify your status to your social worker/healthcare provider. Once that is returned, we will communicate with you regarding your potential grant. Please initial that you understand this: _____

Let's Stay in Touch

How did you hear about Hope Chest for Breast Cancer Foundation?

[ ] Medical Provider/Social Workers

[ ] Friend/Family Member

[ ] Hope Chest Website

[ ] Advertising

[ ] Other: _____

Share My Story

I would like to share my story, my breast cancer journey and how Hope Chest for Breast Cancer Foundation has helped me. Please contact me.

Yes No

Newsletter:

I would like to keep up to date on Hope Chest for Breast Cancer Foundation's work in the community. Please include me on your newsletter and mailing distribution.

Yes No

You will be contacted after your application is submitted and verified. We typically will contact you via the email you provided. If you have any questions, please contact foundation@hopechest.com.