Pattie B. Jackson Memorial Award

"Emergency Grant Supporting Breast Cancer Survivors"

Grant Application

This application aims to identify current breast cancer patients who are in *immediate* need of financial assistance to help ease their economic burden(s) incurred since receiving on-going breast cancer treatment.

Disclaimer: Please note by completing and submitting this application, you are giving consent to disclose HIPAA related information that will be used in determining your eligibility of this financial award. Also, please note that submitting this application does not guarantee automatic selection to receive a financial award.

Name:_____

Telephone No.:_____Email:_____

This grant is provided to those that are residents of the Gulf Coast area. Note: You may be asked to provide proof of residency, if selected.

Address:_____

_____

Time at Residence: _____

Please provide a brief description of the financial hardship and/or economic burdens you have incurred since your breast cancer diagnosis and treatment to include out of pocket medical expenses, unemployment or reduced income, etc.

_____

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Funds may be awarded for all, but not limited to the following: 1) mammography exams, breast ultrasounds and other imaging tests necessary to detect cancer; 2) co-pays and deductibles; 3) home health equipment; 4) living expenses to include groceries, rent, and utilities; and 5) transportation expenses to and from medical appointments as it pertains to receiving treatment for breast cancer. Please provide amount requested to include an itemization of your immediate need based on guidelines specified above.

Total Amount Requested: _____

Itemization:

_____

_____

_____

_____

If you are awarded a grant, you must be willing to submit a written description/testimony of how this award of how this award helped to ease your economic burden and increased your ability to receive timely treatment/medical care. Are you willing to fulfill this commitment? Please circle one.

YES

NO

If you are awarded a grant, you agree to hold harmless any individual or organization to include The Maynard 4 Foundation (its Directors and any affiliates) with the greatest extent permitted by law any seen or unforeseen damages that may occur with the granting of this award. Do you agree to this hold harmless provision? Please circle one.

YES

NO

By signing this application, you certify that the amount requested is for an emergency need and that this grant will bring immediate relief due to the circumstances indicated.

_____ _____

Full Name (Print) Date

_____

Full Name (Signature)

PLEASE ATTACH ANY SUPPORTING DOCUMENTS