Infinite Strength Basic Human Needs Grant Application
for Women in Active Treatment for Breast Cancer

Our mission is to provide financial assistance to underserved single mothers in breast cancer treatment.

Today’s Date *

MM DD YYYY

Patient Information

Name *

First Name Last Name

Address *

You must be a Connecticut or Rhode Island resident to apply.

Address 1

Address 2

City State/Province

Zip/Postal Code

Country

Phone *

(###) ###-####

Email *

Date of Birth *

MM DD YYYY
Ethnic Background *
☐ Native American or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ Asian
☐ Hispanic/Latina White
☐ Caucasian (not of Hispanic Origin)
☐ Bio-racial or Multi-racial
☐ Prefer not to answer

Marital Status *
☐ Single
☐ Divorced
☐ Separated
☐ Widowed

Number of children under the age of 18 that you are financially responsible for: *

☐

Please list names and ages of minor children: *


Please list household members that contribute to your expenses: *


Were you employed at the time of diagnosis? *
☐ Yes
☐ No

If yes, please provide occupation and place of employment:


Are you currently employed? *
☐ Yes
☐ No

If yes, please provide occupation and place of employment:


Are you receiving social security disability? *
☐ Yes
☐ No

If yes, please provide more information:
Is your annual household income 200% or less of the Federal Poverty Level based on your most recent tax return (must be a tax return of at least one year)? *

☐ Yes
☐ No

Diagnosis Information

Date of diagnosis: *

☐ MM
☐ DD
☐ YYYY

Current diagnosis and treatment: *

*Please include type of breast cancer and stage of breast cancer.

Hospital at which you are treated: *

I had or will be having surgery for my breast cancer diagnosis. *

☐ Yes
☐ No

If yes, please provide date:

I am receiving Chemotherapy treatments. *

☐ Yes
☐ No

If yes, please provide most recent treatment date:

I am receiving Radiation therapy. *

☐ Yes
☐ No

If yes, please provide most recent treatment date:

Have you applied to Infinite Strength for financial assistance in the past? *

☐ Yes
☐ No

If yes, please provide date:

Name of Breast Cancer physician: *

First Name

Last Name

Phone number of physician: *

(###) ###-####
Name of nurse navigator or social worker: *

First Name

Last Name

Email of nurse navigator or social worker: *

Phone number for nurse navigator or social worker: *

Bills for which you seek assistance:

Please provide a listing of the bills for which you are seeking funding and the due date. All bills must be due within 60 days and be in the name of the patient. In addition, the bills must have the correct address listed and must include account number, balance, and address to which payments are sent. Bills should include the account number, the current balance due and the complete address to which payments are sent. If you are not requesting the full annual amount immediately, you must complete the application process again to request the additional funds. *

Please use the following format:
Bill #1
Vendor:
Billing Address:
Amount:
Month and Date Due:

Please use this space to provide any information you feel should be taken into consideration as we review your application:

The following MUST be submitted with this application:

A signed letter from your physician on his/her letterhead confirming diagnosis and date of latest treatment. *

A signed letter from the hospital nurse navigator or social worker verifying you qualify for financial assistance. *

Proof of residency if requesting rent or mortgage payment.

By checking this box *

☐ You are certifying that the information and statements contained (including any other material and information submitted) are true and correct and that you give Infinite Strength permission to contact your provided hospital(s), medical professional(s) and/or payer(s) should we have additional questions.

Patient’s Signature *

Today’s Date *

MM

DD

YYYY