Gotta Kiss Cancer Goodbye
Need a Kiss Financial Assistance Program
for newly diagnosed patients and cancer survivors

needakiss@gottakisscancergoodye.org
P.O. Box 752
Orchard Park, NY 14127

APPLICATION FOR FINANCIAL ASSISTANCE

Survivors Name:

_____

Home Address/City/Zip:

_____

Home Phone:_____

Business Phone: _____

E-mail Address:

_____

FAMILY INFORMATION

How many children do you have? _____

Name: _____ Age:_____ Date of Birth: _____

Name: _____ Age:_____ Date of Birth: _____

Name: _____ Age:_____ Date of Birth: _____

Name: _____ Age:_____ Date of Birth: _____

MARITAL STATUS:

Are you married? ___Yes ___No

Are you a single parent? ___Yes ___No

INSURANCE

Do you have health insurance for your family? ___Yes
If yes, What Type:_____ ___No

SERVICES

What is the name and address of the hospital or institute where you are receiving treatment?

_____

Have you received assistance from other agencies/organizations? ___Yes ___No
If so, please note for what, when and amount.

_____

_____

_____

Have you recently applied to other agencies or services for funding? ___Yes ___No
If so, please indicate which and total amount requested.

_____

_____

_____

PROPOSAL SUMMARY – (We have provided a “SAMPLE PROPOSAL SUMMARY” for reference purposes as a separate page of the application).

On a separate page, please provide the following:

1. Please describe what is being requested and why. Be as specific as possible. For example: Rehabilitation program expenses after operation on brain tumor.

2. Please outline all of the current therapies and treatments you or person you are applying for is receiving.

3. Please include a breakdown of the costs – doctor visits, lab costs, therapies, supplements. (The doctor’s office should be able to help you with this)

4. Please make it clear to the committee where you are in your healthcare journey and explain what your goals would be for receiving a grant from Gotta Kiss Cancer Goodbye.

I/We certify that the information on this form is true and complete to the best of my/our knowledge.

The above information is freely given to expedite this grant request.

APPLICANT SIGNATURE: _____

PRITE NAME: _____

DATE:_____

If you are not the survivor, please indicate your relationship to him or her:

_____

Please E-Mail completed application and other required documentation (see Checklist), to:

needakiss@gottakisscancergoodbye.org

OR Mail to:

Gotta Kiss Cancer Goodbye
Need A Kiss Financial Assistance Program
P.O. Box 752
Orchard Park, NY 14127

This application cannot be considered until this form is completed, signed, and all supporting documents are received.

The information included in this application is confidential and for Gotta Kiss Cancer Goodbye use only. Please keep a copy for your records.

Gotta Kiss Cancer Goodbye
Financial Assistance
Program Application Checklist

TO BE CONSIDERED, APPLICATION MUST INCLUDE THE FOLLOWING:

- **Proof of diagnosis from Cancer Center**
- **Completed summary of treatments and explanation of why you are requesting funds**
- **Contact information for doctor**

SAMPLE PROPOSAL SUMMARY

I would like to apply to GOTTA KISS CANCER GOODBYE to help cover my rehab therapy after multiple surgeries for my brain tumor. These costs will be all out-of-pocket because I don't have health insurance and want to go to a world-renowned clinic in Alabama for a one week therapy session.

Here is the cost break down for the services I will be receiving in Alabama:
Travel expenses: $1450
Therapy Sessions: $1700

Total requested: $3150

At this point I need therapy to re-gain use of the left side of my body and physical therapy to help me walk normal again. I would appreciate any help that GOTTA KISS CANCER GOODBYE could give me to help in this journey!

I certify that the information on this form is true and complete to the best of my knowledge.

_____

Applicant Signature **Date**

Please include the following with this application and scan and e-mail to:
needakiss@gottakisscancergoodbye.org

OR mail to:

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Need A Kiss Funding Program
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Orchard Park, NY 14127