466 Kilbourn Rd, Rochester NY 14618 585-662-3555 Email: help@thrivetosurvive.org

APPLICANT INFORMATION:

Name:
Address: (Street, City, State, Zip Code)
Phone Number: **Home:** **Cell:**
Date of Birth:
Email:
HOUSEHOLD INFORMATION:
Marital Status: (circle one) Married Single Divorced Widowed Partner **Name of partner, husband or wife:**
Children Living in Household: (Names and Ages)

Use space below to describe how receiving this grant will help you Thrive through your diagnosis.

Would you be interested in learning more about:

_____Thrive to Survive (We need help spreading the word to others)

_____Support Groups

_____ Survivor Wellness Programs

_____How to support TTS: Planned Giving, Memorial Donations, Tributes, Bequeaths, Corporate Partners, Volunteering

How did you learn about Thrive to Survive?

Authorization of Release of Information/Notice of Privacy

By signing this release, you hereby authorize Thrive to Survive (TTS) to contact any party for information directly related to this grant application and making a decision to approve or deny the financial grant for assistance. TTS will demonstrate respect for your confidentiality, privacy, and security. Records and information are protected against loss, destruction, tampering and unauthorized access or use.

Applicant's Signature: Date:

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Employment & Insurance:	**Diagnosis Verification Information:**
Are you currently: (Circle One) Employed Retired Disabled	Date of Cancer Diagnosis: Diagnosis Name and Staging:
Applicant's Employer Info: (Name/Address/Phone) Are you currently able to work? (circle one) Yes or No If not, when do you anticipate returning to work? (date)	**Treatment Information:** Surgery (Date & Procedure):
Applicant's Health Insurance: Do you have health insurance? (Circle One) Yes or No Insurance Company Name:	Chemotherapy: (treatment dates and names of therapies used)
Income Sources:	
If unable to work are you receiving: (circle one for each question) Social Security Disability Yes or No Disability Yes or No Unemployment Yes or No Workers Compensation Yes or No Veteran's Benefits Yes or No SNAP Benefits Yes or No	Radiation: (treatment dates)

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Cancer Oncologist, Surgeon or Radiologist Written Verification: (Required)

Please request from your treating cancer doctor to provide you a letter verifying cancer diagnosis and treatment information. Specifically, we will need verification on type of cancer treatment you are receiving, treatment dates, as well as diagnosis. Letter needs to be provided on official letterhead and hand signed by doctor.

Please review our instruction page to make sure you submit all documentation. Any application received with missing documentation, will be returned unprocessed.