

Special Needs Grant Application
Breast Cancer Assistance Group of the Monterey Peninsula
(Please PRINT)

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Daytime phone _____ Evening phone _____

Best time(s) to call _____ Email _____

Contact person if we are unable to reach you _____ Phone _____

May we identify ourselves as BCAG when leaving a message? Yes No

Employer _____ Are you currently employed? Yes No

If not, what is your employment status (medical leave, disability, etc.) _____

May we contact your employer if the need arises in order to assist you? Yes No

Your physicians are: _____

Do we have permission to contact the physicians listed above to confirm your diagnosis, treatment, or needs? Yes No

Do we have permission to contact their billing departments to arrange for payment, should the need arise? Yes No

Do you have children living at home? Yes No Ages _____

What is the financial need that you have as a result of breast cancer? Please describe your special circumstances so that we may understand your situation. Use additional sheets of paper, if necessary.

What is the amount of your request? _____

Is there anything else that we should know about you or your situation when reviewing your request? Please attach copies of bills, letters, or other relevant information that clarifies your request.

Signature

Date

Complete this form and mail to: Breast Cancer Assistance Group
P. O. Box 221582
Carmel, CA 93922

For more information, call: (831) 649-6365.