2024 Financial Assistance Grant Application

Applicant Information:

Full Name:_____ **Date of Birth:**_____*

Date of Diagnosis: _____ **Diagnosis:** _____

Treatment Status (circle one): Active Treatment Break Completed Protocol date: _____**

Race:_____***

Phone number: _____ **Email address:** _____

Oncologist Information:

Oncologist: _____ **Phone Number:** _____

Practice: _____****

Assistance Information:

What financial assistance have you already received (or applied for) from your providers or other charities?

What will you do with any funds received as a result of applying for this financial assistance?

Please sign the statement below:

I certify that the information on this form is accurate. I understand that additional information may be requested.

_____ _____

Signed (Applicant Signature) **Date**

I certify that the above-named individual is a patient currently under my care for a cancer diagnosis. The information on this form regarding diagnosis and treatment status is accurate.

_____ _____

Signed (Oncologist Signature) **Date**

*** Must be between ages 18- 40.**
**** Must be within 12 months unless Stage IV or other extenuating circumstances.**
***** Race is asked for reporting purposes only and won't be considered when approving.**
****** We won't contact your doctor, but ask that they sign to verify you are under their care for cancer.**

Priority will be given to patients local to or receiving treatment in the greater Charleston, SC area.

Please submit via email to The Boon Project at katherine@boonproject.org

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