SENSE of SECURITY

Financial Security for Breast Cancer Patients

Application for Emergency Grant

Please review the criteria for Sense of Security's emergency financial assistance program before you apply. The application must be completely filled out, including referral source—a social worker, oncology nurse, surgical nurse, patient navigator or case manager—for verification of treatment.

PATIENT CONTACT INFORMATION

First Name _____ Last Name _____ DOB: _____
Address _____
City, State, Zip _____ County _____
Cell Phone _____
Patient Diagnosis Date _____ ❑ Surgery ❑ Chemotherapy ❑ Radiation Start_____End _____
Please indicate specific treatment the patient is currently receiving: _____
_____

MEDICAL PROFESSIONAL (Social worker, oncology or surgical nurse, patient navigator, case manager)

Full Name _____ Position/Title _____
Address _____
City, State, Zip _____
Telephone _____ Email _____
As the medical referral, my signature attests to the accuracy of the medical information about this patient.
Referral Signature _____Date_____

REQUEST INFORMATION

Sense of Security can provide funds one time up to $500. Receipt of this grant prevents a patient from applying for sustained financial assistance support in the future.

Monthly Household Income $_____
Monthly Household Expenses: $_____

Please describe the exact nature of your need: _____
_____

HOW CAN WE HELP?

Select from the following and we will provide up to $500.

❑ Housing *(Send Landlord/Mortgage Bill)*
❑ Utilities (send copies of bills)
❑ Car payment (*send bill)*
❑ King Soopers Groceries/ Gasoline Card
❑ Car repairs *(send bill)*
❑ Insurance payment *(send bill)*

Signatures on this form indicate the patient and referral source have both read and understand the program description of Sense of Security's Funds.

Signatures: _____ _____
Executive Director Patient

1385 S Colorado Blvd A-714 | Denver CO 80222 | senseofsecurity.org
303-669-3113 | grants@senseofsecurity.org