



New Hampshire Breast Cancer Coalition
NHBCCC Support Services Fund Financial Assistance Application
P.O. Box 643, Nashua, NH 03061-0643

ssf@nhbcc.org

Name: _____ Age: _____ F/M: _____

Street: _____ City: _____, NH, Zip _____

Phone Number: _____

E-mail Address: _____

1. Have you been diagnosed with breast cancer? YES ___ NO ___ YEAR _____

2. Are you currently under treatment for breast cancer? YES ___ NO ___

3. Describe Service(s) or Expense(s) for which you are seeking assistance.

_____ COST _____

4. Enclose a copy of the bill that needs to be paid or an estimate of the service not yet received. Be sure to include the address of where the bill's payment must be sent. **We do not send checks directly to applicant.**

5. Is all or part of this service or expense covered by your insurance, Medicaid/Medicare, hospital charity care or state/city/town programs? YES ___ NO ___

6. Reason you require assistance. Use the back of this application if you need more space.

7. Name of your Social Worker (**required**): Name _____

Phone: _____ Email: _____ Organization: _____

8. How did you hear about this Fund? _____

9. Have you applied to the Fund in the past? No ___ Yes ___ Year _____ Not sure _____

For future funding purposes, please help us by completing the following information:

Are you: Hispanic/Latina ___ White ___ Black/African American ___ American Indian ___
Asian or Pacific Islander ___ Other _____

The media frequently asks us for the personal stories of those we have helped. Would you be willing to share how the Support Services Fund has helped you? Yes ___ No ___

I understand that the NHBCCC Support Services Fund is available only if I have a financial need not met by other resources. I understand that the NHBCCC Support Services Fund Committee has final approval of this application and reviews each application on an individual basis.

Signature: _____ Date: _____