Application for Assistance

Application Contact Info:
Embrace Your Sisters
P.O. Box 127
Honeoye Falls, NY 14472
585-624-9690

PERSONAL INFORMATION	
Applicant Name	
Address (attach proof, i.e. driver's license)	
Email Address	
Home Phone	
Other Phone	
Date of Birth	
Social Security Number	
Own, Rent, or Live with Friends/Family (I*f you own home, please indicate current value and monthly mortgage payment. If you rent, indicate monthly rent payment.*)	
Names and Ages of People in household (*attach separate sheet if needed*)	
MEDICAL	
Physician Name/Address	
Physician Phone	
Diagnosis/Stage/Treatments/Prescriptions (*attach documentation*)	
Date of Diagnosis	
INCOME & EXPENSES	
Bank Accounts & Balances	
Assets-Home/Vehicles/Stocks, etc. (*attach separate sheet if needed*)	
Monthly Household Income/Source of Income. *Please provide most recent 4 pay stubs and last year's tax return.*	
Total Monthly Expenses: (*attach detailed list of all expenses*)	

I authorize my physician (named above) to verify above information to Embrace Your Sisters (EYS) regarding my breast cancer diagnosis and treatment.

I also verify that all of the above information is true and correct.

______________________________________ ____________________

Applicant Signature **Date**