Friends After Diagnosis
serving women with cancer

DIRECT SERVICES GRANT APPLICATION

SECTION I: APPLICATION INFORMATION

Recipients of funding for this award must be Florida residents (residing in Indian River or Saint Lucie County) in active treatment for cancer and have been impacted financially. Please complete all sections of the application.

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Email: _____

SECTION II: DEMOGRAPHIC INFORMATION

Please check all that apply:

Race:

- White
- Black or African American
- American Indian and Alaska Native
- Asian
- Native Hawaiian and Other Pacific Islander
- Other/ Unknown/Choose not to disclose

Ethnicity:

- Hispanic
- Not Hispanic

SECTION III: MEDICAL CERTIFICATION

I certify that the patient listed above is in active treatment for cancer.

Treating Physician: _____ Date: _____

Address: _____

Phone:_____

Doctor's signature: _____

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SECTION IV: REQUESTED SERVICES

Services	Amount Requested
• Groceries	_____
• Transportation	_____
• Utilities	_____
• Housekeeping	_____

SECTION V: SELF CERTIFICATION

I, _____, certify that I am in cancer treatment and have been adversely impacted financially.

Print Name: _____

Signature: _____ Date: _____

SECTION VI: TO BE COMPLETED BY FAD STAFF ONLY

Application Received:_____ Date: _____

Assessment Completed:_____ Date: _____

Eligibility:_____ Date: _____

Notes:_____

_____

_____

_____

_____

Staff: _____ Date: _____