

The Connecticut Breast Cancer Coalition Foundation

The Connecticut Breast Cancer Coalition Foundation (CBCCF) is a grass roots advocacy and education group dedicated to eradicating breast cancer.

CBCCF works to support and enhance the lives of women in Connecticut who are fighting breast cancer.

Requests for grants

CBCCF has established an **emergency fund** to help women who have a financial need associated with or arising from the diagnosis or treatment of breast cancer.

Applicants must be undergoing acute breast cancer treatment such as IV chemotherapy, radiation therapy or surgery.

Each request will be reviewed by the Emergency Fund Board, and decisions will be made in accordance with the availability of funds and the need of the applicants.



Connecticut Breast Cancer
Coalition Foundation
P.O. Box 1721
Litchfield, CT 06759

(860) 984-6215
Fax: (203) 886-1006
E-mail: info@cbccf.org

www.cbccf.org

The Emergency Fund

Need a little?

The Breast Cancer Emergency Fund provides grants to women with breast cancer who need financial assistance to help them through a difficult time.



Application

Please complete the following information.

Name: _____

Address: _____

(Street)

E-mail: _____
(City, State, Zip)

Home phone: _____

Work phone: _____

Best time to call: _____

May we identify ourselves as the CBCCF
when leaving a message?

- Yes No

Your hospital: _____

Oncologist: _____

Phone: _____

May we contact your oncologist or cancer
care coordinator for more information?

- Yes No

**Mail or fax your completed
form to address on back.**

Financial need

Describe your financial need as a result of
the diagnosis or treatment of breast cancer.

Describe the special circumstances that
have caused you to ask us for grant.

Amount requested: \$ _____
Maximum \$150. One time only.

Patient signature: _____

Date: _____

Verification of diagnosis

This area must be completed and signed by
your oncologist or cancer care coordinator.

Date of diagnosis: _____

Stage of breast cancer: _____

- New diagnosis Recurrence

In active treatment? Yes No

If YES, please indicate type of treatment.
(Check all that apply.)

- Chemotherapy Radiation Surgery

Hospital: _____

Address: _____

(Street)

Phone: _____
(City, State, Zip)

Fax: _____

E-mail: _____

Signature of cancer care coordinator: _____

Print name and title: _____
