PO Box 322, Canandaigua, NY 14424
Embraceyoursisters.org / Embraceyoursisters.com
585-624-9690

APPLICANT NAME: _____

ADDRESS: _____

PHONE: _____

EMPLOYER: _____

PHONE: _____

SPOUSE'S/PARTNER'S EMPLOYER:

_____

PHONE: _____

NUMBER OF PEOPLE LIVING IN HOUSEHOLD (including applicant): _____

NAMES, AGES & RELATIONSHIPS OF HOUSEHOLD MEMBERS:

_____

_____

_____

HOW DID YOU HEAR ABOUT US?

__Doctor __ Friend __ Relative __ Internet __ Other (please explain) _____

Have you applied to us before? __Yes __No If Yes, when _____

INCOME:

Applicant's Income $_____ (weekly/biweekly/monthly)

Spouse's/Partner's Income $_____ (weekly/biweekly/monthly)

Child Support/Alimony $_____ Unemployment: $_____

SSI/Disability $_____ Pension: $_____

Food Stamps $_____

Other Household Income ___Yes ___ No If Yes, List:
$_____

Total Monthly Income: $_____

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Monthly Expenses:

Rent/Mortgage: $_____ Utilities: $_____

Prescribed Medication: $_____ Telephone: $_____

Food & Supplies: $_____ Childcare: $_____

Insurance Premiums: $_____

Other Expenses: ___ Yes ___ No If yes, List: _____

_____ **Total**

Monthly Expenses: $_____

Resources:

Checking & Savings Account Balances: $_____ $_____

Stocks, Bonds, CD's, IRA's: $_____ $_____

Other Resources: $_____

Total Resources: $_____

Home/Other Property:

Mortgage Name: _____ Mortgagee Name: _____

Address: _____ Address: _____

If requesting mortgage payment also include amount. If requesting rental payment, include Landlord's name and address as well as amount.

Embrace Yours Sisters does not discriminate on age, sex, race or marital status.

What Bills Do You Need Assistance With?

_____

Please include copies of any bills that you would like help with. EYS does not pay directly to recipients; we will send any money to Utility Companies, Landlords, Mortgage holders, etc. directly.

I _____ declare all information to be true and accurate.

Signature: _____ Date: _____

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Instructions For Application:

To apply for financial assistance from *Embrace Your Sisters*, submit a completed and signed application along with supporting documentation. In order for you application to be approved, the following documents must be included:

__Completed application

__Photo ID

__Proof of Income (applicant and all household members)

__Last 5 pay stubs-if employed

__Previous year's income tax return

__A statement from your Oncology physician (form is included), stating the date of diagnosis, diagnosis and treatment regimen

__Statements (savings, checking, retirement accounts, 401 plan)

__A copy of the bills for which you are requesting assistance

__Sign and date form.

Retain a copy for your records

Please mail completed application and all supporting documentation to:

Embrace Your Sisters
PO Box 322
Canandaigua, NY 14424

For questions about Financial Assistance and completion of application, please contact Embrace Yours Sisters at: 585-

624-9690

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Take this form to your doctor, return it completed and signed with your application.

Patient name: _____

Patient date of birth: _____

Physician's name: _____

Physician's address: _____

Physician's phone: _____

Date of diagnosis: _____

Diagnosis:_____

_____

_____

Currently in treatment Yes___ No ___

Treatment plan: _____

_____

_____

Medications prescribed: _____

Specific physical limitations: _____

Is patient able to work at this time? __ Yes __No

Comments:

Physician's Signature _____ Date _____