INDIVIDUAL GRANT APPLICATION

Meeting the Needs of those Fighting the Cancer Battle Where They Stand.

Amber's Antibodies, Inc. is a non-profit organization (501c(3)), dedicated to helping local Southwest Florida families diagnosed with cancer, in need of financial assistance.

PLEASE FULLY COMPLETE THIS APPLICATION TO BE CONSIDERED TO RECEIVE A GRANT.

DATE OF APPLICATION: _____

APPLICANT'S NAME: _____

STREET ADDRESS: _____

CITY:_____ STATE: _____ ZIP CODE:_____

E-MAIL ADDRESS: _____

PHONE NUMBER: _____ ALTERNATE #:_____

BIRTHDATE: _____

CANCER DIAGNOSIS DATE: _____

DIAGNOSIS/CANCER TYPE: _____

DOCTOR/ONCOLOGIST: _____

CURRENT TREATMENT: _____

PAST TREATMENT(S): _____

CURRENTLY HOSPITALIZED (CIRCLE ONE): YES NO

HOW DID YOU HEAR ABOUT AMBER'S ANTIBODIES AND OUR GRANT PROGRAM?

_____

HAVE YOU APPLIED FOR AN AMBER'S ANTIBODIES GRANT IN THE PAST (CIRCLE ONE)? YES NO

INSURANCE INFORMATION:

a.) DO YOU HAVE INSURANCE: YES ☐ NO ☐ (If YES, answer b and c below))

b.) TYPE OF INSURNACE: PRIVATE ☐ MEDICARE ☐ MEDICAID ☐ SUPPLEMENT ☐

c.) ANY OTHER INSURANCE/COVERAGE INFORMATION (EX. PROVIDERS, WHAT THEY COVER):

_____

_____

PLEASE FULLY COMPLETE THIS APPLICATION FOR GRANT CONSIDERATION

1. PLEASE BRIEFLY TELL US YOUR CANCER STORY (ATTACH ADDITIONAL PAGES IF DESIRED):

_____
_____
_____
_____
_____
_____

2. TELL US ABOUT YOUR FAMILY (SPOUSE, KIDS, AND OTHERS DEPENDENT ON YOU, ETC.):

_____
_____
_____
_____
_____

3. EMPLOYMENT & INCOME INFORMATION

a.) CURRENT MONTHLY HOUSEHOLD INCOME (POST DIAGNOSIS - INCLUDE ALL SOURCES OF INCOME- SPOUSE, DISABILITY, SSI, ETC.): _____

b.) PREVIOUS (PRE-DIAGNOSIS) MONTHLY INCOME: _____

4. PLEASE TELL US ABOUT YOUR ANTICIPATED MEDICAL AND TRAVEL EXPENSES FOR TREATMENT? (ATTACH ADDITIONAL PAGES IF NEEDED): _____

_____
_____
_____

5. LIVING ARRANGEMENT: CHOOSE ONE: OWN ☐ RENT ☐ OTHER ☐ _____

CHOOSE ONE: HOUSE ☐ CONDO ☐ APARTMENT: ☐ OTHER: ☐

a. MONTHLY MORTGAGE/RENT PAYMENT AMOUNT: _____

b. IF OWNED, ESTIMATED VALUE OF HOME: _____

c. AMOUNT OWED ON HOME (MORTGAGE AMOUNT): _____

PLEASE FULLY COMPLETE THIS APPLICATION FOR GRANT CONSIDERATION

This Application must be fully completed to be considered for a grant from Amber's Antibodies. Additional information may be requested in connection with the review of your application, including more details of your financial situation.

You should expect a response from our Board in approximately 90-120 days following submittal of your application.

You hereby authorize Amber's Antibodies to disclose your information to our Board of Directors, and others as necessary in making a decision on your Application/GRANT. In addition, you agree that Amber's Antibodies may use your name and general health diagnosis (but not your financial information) on our website and other marketing and media.

Signature: _____
Print Name: _____
Date: _____

Parent/Guardian signature if Applicant is a minor:
_____
Print Name: _____
Date: _____

Return to:

Amber's Antibodies, Inc.
2338 Immokalee Road, Suite 342
Naples, Florida 34110

OR

info@ambersantibodies.com

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