Breathing Room Foundation

For Families Affected by Cancer

Nomination Form

Applicant's Information (Individual Diagnosed with Cancer)

Name: _____
Street Address: _____
City:_____ State: PA Zip Code: _____County:_____
Home phone: _____ Work phone: _____
Email address: _____
Date of birth: _____/_____/_____ Gender: M or F
Age: _____ Race: _____

Diagnosis and Treatment Information

Type of Cancer: _____
Date of Diagnosis: ___/___/___ New Diagnosis or Recurrence? Yes No
Doctor's Name: _____ Metastatic Disease? Yes No
Doctor's Phone: _____

Family Information (for inclusion in special programs)

Spouse/caretaker: _____ Relationship: _____
Caretaker contact information: Phone_____Email:_____
Number of people living at home: _____ Number of children in home: _____
Names and ages of Children living in the home: _____
_____

Income Level: Is this family considered low Income as dictated by PA's standards: Yes_____No_____

Referral Information

(This section must be completed by an attending doctor, social worker, or other healthcare professional)

Name: _____ Title: _____
Phone number: _____ Email: _____
Affiliation (Hospital/Clinic): _____
Address: _____

Signature of person completing this section: _____

ONLY COMPLETE APPLICATIONS WILL BE REVIEWED, SO PLEASE BE SURE ALL AREAS ARE FILLED IN.
Please mail form to: P.O. Box 287 Jenkintown, Pa 19046 or fax to: 888-852-6190

Statement of Need

(This portion to be completed by the person being referred for assistance. If the applicant is unable to furnish a statement, a nominating individual may write on their behalf.)

Please use the space below to write a brief statement describing your difficulties RELATED to your cancer diagnosis and the areas in which you need assistance.

I hearby certify that the information provided in all parts of this application is truthful and accurate.

Applicant's Signature:_____ Date _____