Feisty Fighters
Grant Application Requirements

Thank you for your interest in Feisty Fighters grant program. We are working to make this application grant process easy and brief for you during what is already a stressful time for your family. We appreciate your patience in thoroughly filling out this application to the best of your abilities.

Important Application Guidelines and Process:

- Applicant must have a cancer diagnosis
- Must be in active treatment
- Must be a US Citizen
- Must be living within South Dakota and/or within a 100 mile radius of Sioux Falls (as the crow flys)
- Verification of diagnosis and treatment must be submitted with application.
    - Letter must be on letterhead
    - Acceptable sources of medical verification are: oncologist, registered oncology nurse or licensed medical social worker
- Incomplete applications will not be accepted or processed. **Please ensure all fields are fully completed**, including date of birth, citizenship status, and any financial hardship information. Questions regarding applications may be directed to Feisty Fighters via phone (605-214-5725) oremailed to (mary@feistyfighters.org).

Applications can be mailed to:

Feisty Fighters c/o Mary Lloyd-Huber

150 E. 4th Place #600

Sioux Falls, SD 57104

-Or-

Applications can be scanned and emailed to:

Mary@feistyfighters.org

Visit our website: feistyfighters.org

Feisty Fighters Grant Application

Personal Information:

Applicant's Name (First & Last):_____ **Applicant's Gender: M / F**

Applicant's Date of Birth:___/_____/_____ **Are you a citizen of the U.S (circle one)? Yes / No**

Applicant's date of cancer diagnosis:_____/____/_____

Address: _____

City:_____ **County:**_____ **State:**_____ **Zip Code:** _____

Home/Cell Phone #:_____ **Email Address:**_____

Do you have a Website? _____
(Caring Bridge, Care Pages, Facebook, etc.)

Number of Household Income Earners: Full Time:_____ Part Time: _____

Dependents living in the home and their age:(List all, if applicable): _____

_____

Are you a previous grant recipient? Yes ☐ No ☐ If yes, when? _____

How did you learn about Feisty Fighters? (Please provide the referral name in space provided)

- ☐ Medical personnel: _____
- ☐ Social worker/care coordinator: _____
- ☐ Website_____
- ☐ Feisty Fighters event: _____
- ☐ Friends/Family:_____
- ☐ Past recipient: _____
- ☐ Other (please specify):_____

Contact information of the named referral (required):

E-mail:_____

Phone #: _____

Financial & Employment Impact of Applicant's Medical Situation:

Please enter total dollar amount for each of the following categories in relation to your loss of income and expenses during treatment.

	$ Per Week		Potential/Est. # of Weeks of treatment		Total Estimated $
Loss of salary/income due to additional time away from work (clinic appointments, day procedures, etc.)		X		=	
Additional travel-related expenses: (gas, parking, taxi fares, airfare, etc.)		X		=	
Additional Medical expenses: (co-pays, deductibles, Out-of-pocket expenses, etc.)		X		=	
Other additional related expenses: (childcare, meals, hotels, household home upkeep, etc.)		X		=	

What is your health insurance out of pocket max per/year $_____

Are you on Medicare*/ Medicaid/ No I am not? **(circle one)**

*If yes, what additional supplements do you have? _____

Other/additional requests from Applicant (Circle all that apply)

* I would appreciate being added to your prayer chain: Yes No

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Consent & Authorization To Use Your Story:

Family of our recipients often ask us, "How can we give back to Feisty Fighters?" and there is a very simple answer. One of the most important ways for Feisty Fighters to "give back" is to share their family's story with others. It is extremely important for future donors to hear the impact that Feisty Fighters has made in the lives of families. Periodically, we look for families who are willing to share their family's story to help bring awareness to others about the important service that Feisty Fighters offer. If you are comfortable in allowing us to get to know you better and to share your story with us, please tell us more about you. **Please attach any information/story to this application.**

May we share your family's story in the future? Yes ☐ No ☐

Application Consent and Authorization:

For monetary grants ONLY, applicant cannot personally be related to any board member of the Feisty Fighters and/or have any personal or business relationship with any board member of the Feisty Fighters.

I have read the guidelines and understand them. I attest that all information on this application is true to the best of my ability. I authorize Feisty Fighters and my medical care provider to discuss my family's medical information pertinent to this case.

Signature of applicant:_____ **Date:** _____