

**Connie J Goodale Breast Cancer Foundation**  
**APPLICATION FOR ECONOMIC ASSISTANCE**

To qualify to receive assistance, recipients must have breast cancer and live in Palm Beach County. Each application should include a copy of the recipient's driver's license, proof of residency in PBC such as a current utility bill and proof of breast cancer diagnosis.

Return this completed application in one of the following ways:

- ❖ fax to 561-966-8699
- ❖ Mail to P.O. Box 15015, West Palm Beach, FL 33416

**Tell us about your residence:**

List first and last name of person requesting assistance: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip code: \_\_\_\_\_

**\*\*Please provide phone numbers/e-mail address where you can receive a secure message.\*\***

Primary Phone #: ( ) \_\_\_\_\_ Alternate Phone #: ( ) \_\_\_\_\_ Work Phone #: ( ) \_\_\_\_\_

E-mail: \_\_\_\_\_

**Tell us about the people in your household:**

List other permanent members of your household including children.

Household Member #1:

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Gender: Female Male (Circle) Date of Birth: \_\_\_\_\_

Household Member #2:

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Gender: Female Male (Circle) Date of Birth: \_\_\_\_\_

Household Member # 3:

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Gender: Female Male (Circle) Date of Birth: \_\_\_\_\_

If there are other people in your household, use additional sheets.

**Please list employment data:**

Are you employed? YES NO

If so, employer's name: \_\_\_\_\_

Employer's address: \_\_\_\_\_

Job Title: \_\_\_\_\_  
How long have you been there? \_\_\_\_\_  
Phone number of person who at employer's who can verify: \_\_\_\_\_

Other household member's name: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's address: \_\_\_\_\_  
Job Title: \_\_\_\_\_  
How long has person been employed there? \_\_\_\_\_

If other household members are employed, use additional sheets.

**Tell us about changes you expect regarding employment and/or benefit status:**

Are you or is any household member awaiting approval for any kind of benefits (disability, unemployment, and so forth)? **YES NO**

If so, which household member? \_\_\_\_\_ What kind of benefit is it and when should it start? \_\_\_\_\_ Do you expect any other changes to income or benefits you haven't already shared with us?  
\_\_\_\_\_

**Tell us about your bills:**

List the **average monthly** amounts paid for the following items.

Please complete information for ALL monthly bills, not just bills you need assistance with.

Rent/Mortgage \$ \_\_\_\_\_ /mo. Has a late notice been received? YES NO

Do you pay association dues? (Homeowner Association)? YES NO If so, how much are the dues? \$ \_\_\_\_\_ Are they behind? YES NO \_\_\_\_\_ If so, what is the balance? \$ \_\_\_\_\_

Is your home currently in foreclosure? YES NO I don't know

If so, what is the amount you are behind? \$ \_\_\_\_\_

Avg. Electric \$ \_\_\_\_\_ /mo. Has a late notice been received? How much is owed? \$ \_\_\_\_\_

Avg. Water \$ \_\_\_\_\_ /mo. Has a late notice been received? How much is owed? \$ \_\_\_\_\_

Avg. Propane/Natural Gas \$ \_\_\_\_\_ /mo. Has a late notice been received? \_\_\_\_\_ How much is owed? \$ \_\_\_\_\_

List the average monthly amounts paid for the following items: Child Care \$ \_\_\_\_\_ /mo.

Car Payment \$ \_\_\_\_\_ /mo. Car insurance \$ \_\_\_\_\_ /mo. Home/Cell Phones \$ \_\_\_\_\_ /mo.

Cable/Satellite \$ \_\_\_\_\_ /mo. Gas/Transportation \$ \_\_\_\_\_ /mo. Food/Personal Items \$ \_\_\_\_\_ /mo.

Other monthly bills: \$ \_\_\_\_\_ /mo Explanation: \_\_\_\_\_

Use additional sheets if necessary.

**Tell us about your medical history:**

Name of your oncologist: \_\_\_\_\_

Phone number: \_\_\_\_\_

Summary of your medical history including but not limited to: diagnosis date, treatment, surgeries:  
\_\_\_\_\_

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Use additional sheets as necessary.

**Tell us about your request:**

How did you hear about our program? \_\_\_\_\_

Have you applied for assistance from The Connie Foundation before? YES NO

If so, When? \_\_\_\_\_

What do you need assistance with (Rent/mortgage, Utilities, medical expenses and so forth) and for what amount(s)? \_\_\_\_\_

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Use additional sheets as necessary.

Write a summary of what has happened that caused you to require assistance with these bills?

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Use additional sheets as necessary.

The information on this application is true to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date