



Application For Assistance

Applications are accepted from the 1st through the 7th of every month.

Date: ____/____/____

Name: _____

Mailing Address: _____

Phone: ____ - ____ - _____

Email: _____

Birthdate: ____/____/____

Last 4 Digits of SSN: _____

Date of Diagnosis: ____/____/____

Description of Diagnosis (please include your staging and any oncotype information, such as Triple Negative, ER+, etc.)

Current Average Household **Monthly** Income: _____

If you are being assisted by a social worker or patient navigator with your application, please provide their name and the name of their facility/hospital:

Are you currently actively employed: ___Y ___N

Are you financially responsible for any minor children: ___Y ___N

Are you the sole income provider for the household: ___Y ___N

Are you currently in active treatment: ___Y ___N

Have you received assistance from any other organization in the last 3 months: ___Y ___N

**Please select the category of assistance you are requesting:
(Please select only ONE category.)**

- _____ Housing (mortgage/rental; **cap of \$1,500**)
- _____ Medical Bills (**cap of \$1,000**)
- _____ Utilities (gas, power, water, etc; **cap of \$750**; multiple utilities may be submitted)*
- _____ Transportation (car payment, repair; **cap of \$750**)
- _____ General Use Gift Card (value of \$500)
- _____ Lymphedivas Gift Certificate (compression garments; \$250 value)
- _____ A World Of Pink Gift Certificate (Good for one bra and two prosthetics)

You MUST include the following supporting documents with your application:

- _____ A letter from your oncologist or surgeon that confirms your diagnosis of breast cancer OR a copy of your pathology report.
- _____ A copy of the bill(s) that you are requesting assistance with, if applicable. Please make sure they include your name, address, account number, and pay by phone information or a mailing slip.
- _____ A copy of your lease that includes payment name and address. (Rental assistance only)
- _____ A personal letter that tells us about your current situation and diagnosis. Please include any information you feel will help us make a decision about your assistance.

You may submit your application and supporting documents in one of the following ways:

1. Fax a copy to 615-634-1220, ATTN: Review Committee
2. Mail a copy to Remember Betty, Attn: Review Committee, 100 Andover Park W, Suite 150, Box 375, Tukwila, WA 98188

Signature of Applicant: _____

APPLICATION FAQ:

Applications are accepted from the 1st through the 7th of every month, funding permitting.

Applications received after the 7th will not be considered and will not be held over to the next month.

Applications will be reviewed no later than the 20th of the month.

Applicants who are accepted will be notified no later than the 25th of the month via email.

Assistance for those applicants will be disbursed no later than the end of the month.

Applicants may receive assistance that is less than the cap of a category based on the level of need shown.

Due to the volume of applications received, we cannot provide confirmations of receipt.

Inquiries on the status of an application will be answered after the 17th of the month only.

Applicants who receive assistance may reapply in fifteen (15) months. Applicants who do not receive assistance may reapply after three (3) months time.

Please note that Remember Betty receives, on average, upwards of 150 applications per month. Our current funding allows us to accept between 5 – 10 applicants per month to assist. While we would love to assist every applicant who qualifies, it is simply not within our power to do so at this time. We are happy to suggest other organizations and resources to those applicants that we unfortunately cannot provide financial assistance to.

For additional information or questions, please email Bethany@rememberbetty.com