Still I Rise From Cancer, INC.

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Application for Scholarship for Scalp Cooling Treatment

Instructions:
1. Complete the application in its entirety and sign it.
2. Send the application and your documentation by email to scholarships@stillirisefromcancer.org

Information

Name (First and Last): ______________________________

Street Address: ______________________________

City:____________ State:______ ZIP Code:________ Daytime Phone:______________

Date of Birth:______________________

Email:______________________ Gender: (check One) ☐M ☐F

How did you hear about Sill I rise From Cancer, Inc.______________________

Eligibility

Total household income: ____________ My household size: ____________

Required supporting documentation (select one):

☐Copy of the first page of your current tax return

☐Copy of two most recent pay stubs for all employed household members

☐ No income…(If applicant has no income then a letter is required from applicant's healthcare provider, advocate or agency attesting to zero income or if you don't file taxes, submit Form 4506-T from the IRS.)

Do you have health insurance coverage that pays for scalp cooling treatments? ☐Yes ☐NO

Medical Information(Confidential)

Please provide your oncologist's contact information:

Name ______________________________________ Phone: _____________________ Fax: _____________________

Please provide the contact information for the medical facility where you will be receiving your chemotherapy treatments:

Name ___________________________________Phone: _____________________ Fax: ___________________

Street Address _______________________________ City ________________________State_____ Zip ______________

Please select the **<u>Type</u>** of cancer with which you've been diagnosed. Also circle the Stage if you know.

Type	Stage (circle one)	Type	Stage (circle one)
☐ Breast	I II III IV	☐ Stomach	I II III IV
☐ Colorectal	I II III IV	☐ Uterine	I II III IV
☐ Liver	I II III IV	☐ Ovarian	I II III IV
☐ Lung	I II III IV	☐ Urinary	I II III IV
☐ Pancreatic	I II III IV	☐ Brain	I II III IV
☐ Prostate	I II III IV	☐ Oral	I II III IV
☐ Skin	I II III IV	☐ Other: Please specify ____________________	I II III IV

On what date do you expect to receive your first (or next, if you've already started) scalp cooling treatment? __________

On what date do you expect to receive your last scalp cooling treatment?________________________

How many total scalp cooling treatments do you expect you will receive?____________

Optional Information: Please complete any of the following questions that you can.

What chemotherapy drug regimen(s) has your doctor prescribed? ____

How frequently do you expect you will receive chemotherapy treatment (e.g., twice a week, once every three weeks, once a month, etc.)?

Agreement

By signing this application, you signify that you understand and agree to the following:

- I give Still I Rise From Cancer, Inc. permission to verify everything on my application
- Still I Rise From Cancer, Inc. makes no guarantees regarding the appropriateness or effectiveness of any scalp cooling treatment and that I should consult with a medical professional before undergoing scalp cooling treatment.
- All information I have provided in this application is accurate to the best of my knowledge
- I have not been approved nor do I expect to be approved for insurance reimbursements or any other payments from any organization that will help pay the cost of my scalp cooling treatments. (Contributions from friends or family members is ok).
- I understand that Still I Rise From Cancer, Inc. at its discretion determines the scholarship amount that will be paid towards the Scalp Cooling Systems either by a partial scholarship or up to the entire amount of the treatment. I further understand that I am responsible to pay the remainder costs of the treatment should Still I Rise From Cancer, Inc. only pay a partial scholarship.

Applicant's Signature:____Date: ____________________