

Amarillo Annual Breast Cancer Motorcycle Benefit Run
PO Box 2813
Amarillo, TX 79105

ASSISTANCE FUND APPLICATION

NAME: _____
BIRTH DATE: _____
ADDRESS: _____
Social Security Number _____
DAY PHONE: _____
EVENING PHONE: _____
REFERRED BY: _____
PRIMARY CARE PHYSICIAN: _____
ADDRESS: _____
PHONE: _____
ONCOLOGIST: _____
ADDRESS: _____
PHONE: _____
SURGEON: _____
ADDRESS: _____
PHONE: _____

HAVE YOU BEEN DIAGNOSED WITH BREAST CANCER: ___ YES ___ NO

Please complete the following information:

SPECIFIC TYPE OF ASSISTANCE REQUESTED:

Medication(s) by name:

Breast Prosthesis:

Cranial Prosthesis (Wig):

Financial Assistance Needs (List needs, payoff, monthly pymt due related to breast cancer)

Any other need not listed above
(detailed) _____

ANNUAL HOUSHOLD INCOME: _____

FAMILY SIZE (CHILDREN'S NAMES/AGES)

TOTAL HOUSEHOLD ASSETS: _____

INSURANCE PROVIDER AND CONTACT INFORMATION:

TOTAL HOUSHOLD LIABILITIES: _____

OTHER FINANCIAL AID RECEIVED(Amt and from Whom)

: _____

I do ___ do not ___ give AABCMBR permission to use my name for media and advertising purposes.

I do ___ do not ___ give AABCMBR permission to use the nature of my circumstances for media and advertising purposes.

Please read the following information carefully before signing:

I hereby understand and recognize that the Amarillo Annual Breast Cancer Motorcycle Benefit Run fund (the "Fund") is non-profit. The fund has been established for the benefit of those people diagnosed with breast cancer and to provide prescriptions, prosthesis, and/or selected or related items in support of an individual's physical and emotional well-being. The fund will provide grants on an equal opportunity basis and without regard to an applicant's race, color, religion, creed, ethnicity, marital status or sexual orientation. However, the fund is only authorized to provide assistance to those individuals who have demonstrated financial need, which is not covered by insurance.

Accordingly, I hereby certify that the financial information set forth on this application concerning my annual household income, assets, liabilities and insurance provider is true and accurate, and that the purchase of the goods and services that I have requested of the Fund to purchase on my behalf cannot be purchased by me and my family without incurring financial hardship. I further certify that I have been diagnosed with breast cancer and that I and my family do not have insurance coverage which would pay for such goods and services that I have requested the fund to purchase on my behalf. I understand that if any of the information set forth above is false I am subject to punishment.

DATE: _____

SIGNATURE: _____

My signature above grants permission for AABCMBR representatives to contact my physician(s) and insurance company.

Return this application to: ridefortheure@netzero.net or
Ride 4 The Cure PO Box 2813 Amarillo, TX 79105