Date Received by GT:

_____

Geaux Teal Ovarian Cancer Awareness Financial Grant and Aid Application

Please print and mail application to the following address. Applications will not be accepted via email.

Geaux Teal
Attn: Grant Committee
PO Box 87228
Baton Rouge, Louisiana 70884

Today's date: _____

Applicant's Full Legal Name: **Applicant's Date of Birth:**

_____ _____

Address (City, State, Zip):

_____

Gynecological Oncology Diagnosis and stage, if known:

_____

Date of Diagnosis (Month & Year): _____

Current status (circle one): Newly diagnosed Active Treatment Recurrence Hospice eligible

Primary GYN Oncologist:

_____

GYN Oncologist Address:

_____

Requesting financial assistance for (Check all that apply):

- ☐ ***Travel for Surgery***
- ☐ ***Cancer related medicine & or equipment***
- ☐ ***Extended Inpatient/Outpatient recovery***
- ☐ ***Non-medical expenses***

Treatment Dates:

_____

Hospital/Treatment Facility:

_____

Prescribed Medications:

_____

Current Pharmacy (Name and Full physical address):

_____

Equipment Description:

_____

Parent/Guardian Name #1 (If Applicable):

_____

Parent/Guardian Address:

_____

Parent/Guardian Phone Number:

_____

Parent/Guardian Email:

_____

Parent/Guardian Name #2 (If Applicable):

_____

Parent/Guardian Address:

_____

Parent/Guardian Phone Number:

_____

Parent/Guardian Email:

_____

If the Geaux Teal Grant is approved, name of individual to whom check should be made payable:

_____

Mailing Address for Check (Address, City, State, Zip):

_____

Has the Applicant applied for financial aid from Geaux Teal before?

_____

Name and relationship of person completing his application:

_____

Healthcare provider (Circle one): MD RN SW

Name: _____

Signature: _____

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