

## The Pink Gravel Fund Grant Guidelines

The purpose of the Pink Gravel Fund is to provide funds to qualified individuals to cover expenses related to the treatment and recovery of breast cancer. Eligible expenses may include medical expenses not covered by insurance; travel or lodging needs when taking treatments; registration fee to participate in that first activity after treatment. Grant request will be considered for no more than \$500 per year, per person. [Note: A cumulative total of \$2000 for grant disbursements to benefit individuals from the effective date of July 1, 2023, through December 31, 2023.]

To qualify for assistance, breast cancer patients/survivors must reside or have a mailing address in one of the following counties: Lyon, Chase, Coffey, Greenwood, Morris, Osage, Riley, or Wabaunsee.

### Application Requirements:

1. The applicant must be a resident of one of the following counties in Kansas: Chase, Coffey, Greenwood, Lyon, Morris, Osage, Riley, and Wabaunsee counties.
2. All the following information must be submitted with the application to be considered for a grant:
  - A. A brief medical history with regard to breast cancer. (Examples: *When was the applicant diagnosed? What symptoms or discomforts is the applicant dealing with?*)
  - B. A statement from the applicant's medical doctor attesting to the medical conditions necessitating treatment or completion of treatment within the last 12 months.
  - C. A brief statement of the financial situation, including information about any medical insurance and expenses not covered by the insurance policy. *Is Applicant on fixed income with increased expenses due to the breast cancer diagnosis or has the diagnosis caused missing extended periods of work or to lose a job?*
  - D. A brief statement telling us what assistance is needed. Provide a list of expenses, real or projected, that have incurred due to a breast cancer diagnosis and tell us specifically what is being requested via this grant application. (Example: *Gas money? Medical bills? Regular bills due to loss of Income? Wigs? Turbans? Reconstruction? Special clothing needs? Or help towards fees to participate in a physical activity after treatment?*)
  - E. A timetable for the expenditures of the grant. (*When is the assistance needed? When do you predict the assistance?*)
3. Applications with attachments should be delivered or mailed to:

Emporia Community Foundation  
527 Commercial St., Suite B  
Emporia, KS 66801

Questions? Contact the Foundation, 620-342-9304 or [loni.heinen@emporiacf.org](mailto:loni.heinen@emporiacf.org).



## Pink Gravel Fund

Provide support for breast cancer patients, survivors, and awareness

## APPLICATION

### Patient Information:

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Applicant Contact Person:** (  ) Check if the contact information is the same as above.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I have been diagnosed with breast cancer, I am receiving breast cancer treatments, or I have completed breast cancer treatments within the last 12 months. I am requesting assistance with costs associated with breast cancer diagnosis and recovery. I hereby give permission to the staff of the Emporia Community Foundation to contact the parties in this application or attachments thereto for purposes of verification.

\_\_\_\_\_

Date

\_\_\_\_\_

Signature of Applicant or Authorized Person

Please attach the following information to this cover sheet: (All items must be completed to be considered for a grant.)

- A. A brief medical history with regard to breast cancer. (Examples: *When was the applicant diagnosed? What symptoms or discomforts is the applicant dealing with?*)
- B. A statement from the applicant's medical doctor attesting to the medical conditions necessitating treatment or completion of treatment within the last 12 months.
- C. A brief statement of the financial situation, including information about any medical insurance and expenses not covered by the insurance policy. *Is Applicant on fixed income with increased expenses due to the breast cancer diagnosis or has the diagnosis caused missing extended periods of work or to lose a job?*
- D. A brief statement telling us what assistance is needed. Please provide a list of expenses, real or projected, that have been incurred due to a breast cancer diagnosis and tell us specifically what is being requested via this grant application. (Example: *Gas money? Medical bills? Regular bills due to loss of Income? Wigs? Turbans? Reconstruction? Special clothing needs? Or help towards fees to participate in a physical activity after treatment?*)
- E. A timetable for the expenditure of the grant. (*When is the assistance needed? When do you predict the assistance will be used?*)

### Submit all application documents to:

Emporia Community Foundation  
527 Commercial St., Suite B  
Emporia, KS 66801

Questions? Contact the Foundation, 620-342-9304 or [loni.heinen@emporiacf.org](mailto:loni.heinen@emporiacf.org).