

Grant Application

Location and Contact Information
First Name Last Name
* IMPORTANT: The Chipstrong Foundation only offers grants to qualifying individuals in Outagamie, Waupaca, and Winnebago counties.
Employment and Household Information
Yes No Are you currently employed and working? Yes No Has your ability to work been limited by your treatment or current health? Yes No Has your household income decreased as a result of your diagnosis or treatment? If the above answer was "YES", how much less is your household monthly income?
Household Income
Monthly Household Wages Monthly Federal/State Government Assistance (Social Security, Stamps, etc.) Monthly Retirement Distribution (if receiving from a retirement fund or annuity) Monthly Alimony or Child Support Monthly Disability (if you are being paid by a disability insurance/plan) Monthly Other Income
Mortgage / Rent Expenses
Do you own or rent your home? Own Rent Other What is your mortgage or rent payment (per month)?
PAGE 1 OT 3 Applications are reviewed the end of each month, and grants will be processed at that time. Please allow up to 45 days for review of your application.



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Household Expenses

What is your monthly utility expense? (Power, Gas, Sewer, Cell, TV, Internet)
What is your monthly car payment(s) (if any)?
What is your monthly food and groceries expenses?
What is your monthly credit card payments (average)?
What are your other expenses (beyond the ones listed above)?

Treatment Expenses

Are you currently covered by Medical/Health Insurance? Yes No Faith based co-ops do not qualify as insurance.
What expenses are not included in your Medical coverage? Deductibles Co-Pay Out-of-Pocket
What is your annual deductible with your Medical/Health Insurance?
Do you have monthly payments established with insurance? 🗌 Yes 🗌 No
If you answered yes above, what is the monthly payment to insurance?
Treatment Details
When was/is your treatment start date? When is the estimated end of treatment?
What type of treatment did/will you receive? 🗌 Surgery 📄 Radiation Therapy 📄 Chemotherapy 📄 Other

Please provide some information about the treatments you have checked above:

PAGE 2 of 3

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Your Cancer Journey

Who referred you to the Chipstrong Foundation?

Tell us about your cancer journey? We want to hear about you and your family and what you're worried about.

Physician Signature

A signed doctor's note stating you are undergoing or will be undergoing treatment is also accepted.

As the physician for ______, I can confirm that this patient is undergoing or will be undergoing cancer treatment. I understand that signing my name is only for the purpose of confirming treatment and will not be used to assume or infer any other information claimed on this document.

Χ_

DATE: _____

Physician Signature

Mailing Application / Thank You!

Thank you very much for taking the time to complete this application. We take all applications into consideration!

Please mail the completed form to:

Chipstrong Foundation N976 West Lake Ct Hortonville, WI 54944