GRANT GUIDELINES
THE TRINA FUND

The Trina Fund was established to help women with breast cancer receive the best possible care by providing resources to assist with transportation costs related to obtaining a second opinion or transportation costs related to receiving treatment for their breast cancer.

Application process: Referrals to the fund may be made by health care providers or non-profit organizations which provide service to cancer patients. Requests for grants should include the name and residence of the individual in need, a brief description of the need, and the amount of the request. The attached form may be used. Individuals to be served must reside in Wisconsin and be seeking treatment at an accredited medical facility in the United States. Funding is limited and individual maximums may apply.

Review of applications: Women's Fund staff will review requests and authorize payment. Staff will rely on the referral organization's personal knowledge of the applicant's situation and financial need as well as the organization's professional judgment that the request is consistent with the intent of the fund. Grant approval and issuance of a check would typically occur within 15 business days of receipt of the request.

Issuance of check: Checks will be issued directly to the referring organization. Checks cannot be made payable directly to individuals.

Appreciation: The Women's Fund will forward to the fund contact any letters of appreciation received from grant recipients.

More information: Questions about the fund or application process should be directed to:

Becky Boulanger
Executive Director
Women's Fund for the Fox Valley Region
P.O. Box 563 | Appleton, WI 54912-0563
phone: 920-830-1290 | fax: 920-830-1293
email: bboulanger@womensfundfvr.org

THE TRINA FUND GRANT APPLICATION

The Trina Fund was established to help women with breast cancer receive the best possible care by providing resources to assist with transportation costs related to obtaining a second opinion or treatment for their breast cancer.

Date: ______________________________ **Amount requested:** $______________

Name of referring organization: ______________________________

Address: ______________________________

Name of individual making referral: ______________________________

Title: ______________________________

Phone: ______________________________ **E-mail:** ______________________________

Name of individual needing financial assistance: ______________________________

City/Town of residence: ______________________________

Briefly describe what type of transportation assistance is required:

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Name and location of medical facility where treatment will be provided:

____

If multiple visits to the medical facility are required, please indicate how many visits you are requesting transportation assistance for and approximate time frame within which visits will take place.

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Check will be payable and mailed to the referring organization. Checks cannot be made payable directly to individuals.

Return this application to: Becky Boulanger
Executive Director
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