THE TRINA FUND GRANT APPLICATION

**The Trina Fund** was established to help Wisconsin 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.

**This form is to be completed by a representative of the referring organization.**

|  |  |  |  |
| --- | --- | --- | --- |
| Date: |  | Amount Requested: | **$** |

|  |  |
| --- | --- |
| Name of referring organization: |  |

|  |  |
| --- | --- |
| Address: |  |

|  |  |
| --- | --- |
| Name of person making referral: |  |

|  |  |
| --- | --- |
| Title: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Email: |  |

|  |  |
| --- | --- |
| Name of individual needing financial assistance:  |  |

|  |  |
| --- | --- |
| City/Town of residence: |  |

|  |  |
| --- | --- |
| Briefly describe what type of transportation assistance is required: |  |

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

|  |
| --- |
| Reason for medical visit: |

|  |
| --- |
|  [ ]  Chemotherapy [ ]  Radiation [ ]  Second Opinion |

|  |  |
| --- | --- |
|  [ ]  Other (list): |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Number of visits: |  | Treatment start date: |  |

|  |
| --- |
| Mileage Calculation: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |       | .16 |  | $      |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Number of miles each way* | x | *Number of Trips* | x | *Cents per mile* | = | *Total Amount*  |

Return this application via email to: grants@womensfundfvr.org

Checks will be made payable to the referring organization.

Checks cannot be made payable directly to individuals.