BoStrong Foundation
5956 Augustine Ave
Elkridge, MD 21075
EIN: 82-2538863

Supporting holistic wellness for young adults fighting cancer

Wellness Grant Application

The BoStrong Foundation supports holistic wellness for young adults fighting cancer. Having choices and understanding options is critical when traveling through a cancer journey. The BoStrong Foundation strives to provide information, education, resources, and shared experience for young adults exploring holistic treatment options.

We know how expensive these alternative therapies can be and the financial stress that comes along with including them in your treatment plan. We want to help. We provide financial support to assist young adults in adding holistic treatment options or using them as a stand-alone option.

Criteria:

1. The patient must be between the ages of 16 and 39
2. The patient must have a diagnosis of cancer.
3. A grant application can be completed on behalf of the patient by a family member or a caregiver.
4. The practitioner must be approved by the BoStrong Foundation
5. The practitioner must be located in the United States.

If you meet these criteria and would like to be considered for a wellness grant, please complete this application. You can submit it to us via email at wellness@bostrong.us or you can print it and mail it to The BoStrong Foundation 5956 Augustine Ave Elkridge MD 21075.

We would appreciate it if you would include at least two photos of yourself along with your application, with at least one taken in a medical setting.

The list below are examples of some of the things that a BoStrong Wellness Grant can be used to support:

- Reiki
- Nutrition
- Massages
- Cost to obtain a medical cannabis card.
- Help with supplements.
- Equipment (i.e. rebounder)
- Namaste Clinic
- Connors Clinic
- Gerson Clinic
- Holistic clinics
- Cranial Sacral
- Acupuncture
- Conferences
- Chiropractic
- Music therapy
- Sound therapy
- Laser therapy
- Holistic infusions
- Testing

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Wellness Scholarship Application

(Use additional pages if necessary)

Name:	**Date of Birth:**	**Application Date:**	
Phone:	**Email:**		
Address:	**City:**	**State:**	**Zip:**
Diagnosis:		**Date of Diagnosis:**	
Primary Oncologist:			
Hospital/Treatment Location:			
For our records, we would like to request an official letter of diagnosis from your oncologist or social worker. Can you provide this? (this can be sent to us separately from this application)		**YES** ◯ **NO** ◯	
Personal Story:			
Why should we consider your application?			
Is there anything else that you would like us to know?			
By signing below, I understand that if my application is approved, I will submit a picture of myself with my approval to be used on our website or social media platforms. You will also agree to the money being sent directly to the practitioner or service provider that you will be seeing. _____ **Signature**			