

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

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](mailto: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



**BoStrong Foundation**

5956 Augustine Ave

Elkridge, MD 21075

EIN: 82-2538863

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## Wellness Scholarship Application

*(Please answer every question. Use additional pages if necessary)*

Name:		Date of Birth:		Application Date:	
Phone:		Email:		Preferred contact method: Email      Text      Call	
Address:		City:	State:	Zip:	
Name of Person Completing Application:			Relationship to Patient:		
Diagnosis:			Date of Diagnosis:		
Primary Oncologist Name and Address:					
Hospital/Treatment Location:					
How did you hear about BoStrong?					
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?					
How can we help? <i>(see partial list on cover sheet)</i>					
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 grant money being sent directly to the practitioner or service provider that you will be seeing.					
_____ Signature					