Breast Cancer
Care Foundation

APPLICATION FOR ASSISTANCE

Today's Date:_______________ Email Address:_________________________________

Name: ____

Date of Birth: _____________ **Race**: _____________ **Ethnic Origin**: __________ **Gender**: _______

Home Address: ____
(street)

_________________________ _____________ ____________________
(city) (State) (Zip)

Work Address: ____
(street)

_________________________ _____________ ____________________
(city) (State) (Zip)

Contact Person: _________________________________ **Work**: ( )______________________

Home Phone: ( ) ______________________________ **Phone**: ( ) ______________________

Number of Persons in Household: ____________ **Total Income in Household**: $__________
(per month)

Type of Assistance Requested: ***Check all that apply.***

- ☐ **Diagnosis**
- ☐ **Transportation**
- ☐ **Medication**
- ☐ **Rehabilitation**
- ☐ **Specific Request: Amount** $______
- ☐ **Treatment**
- ☐ **Medical Supplies**
- ☐ **Other (specify)**

Purpose:______________–

Date of Diagnosis ____________________Planned Treatment: __________________________________

Medical Coverage: ***Check all that apply.***

- ☐ I have private health insurance. Name of Insurer & Contract #_________________________________
- ☐ I have Medicare
- ☐ I have Medicaid in: ☐ D.C. ☐ VA ☐ MD or other state ☐ (specify)_________________________
- ☐ I am uninsured. If not receiving Medicaid, why not ____
- ☐ Other Resources: List any other sources from which you have tried to receive breast care assistance: ____

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Financial Status

Monthly Household Income

	Patient	Spouse/Other
Salary (before taxes)	$__________________	$__________________
Pension	$__________________	$__________________
Social Security	$__________________	$__________________
Retirement	$__________________	$__________________
Social Security Disability	$__________________	$__________________
Interest $ Dividends	$__________________	$__________________
Other	$__________________	$__________________
Total	$__________________	$__________________

To the best of my knowledge the information provided is accurate. Furthermore, I understand that completion of this application does not automatically guarantee granting of funds. All information is strictly confidential and is for BCCF use only. BCCF may discuss this information internally through verbal and electronic means to assess my application. BCCF may also use my financial information to negotiate on my behalf with health providers, credit agencies, or others as needed.

Your Signature: ____ Date: _____________________

Print Your Name: ____

If you have any questions, please feel free to call us at 703-707-9491. Upon completion, please mail or fax this application to:

The Breast Cancer Care Foundation
P.O. Box 101081
Arlington, VA 22210
Fax: 703-991-3252

A board-member of BCCF will contact you as soon as possible.

'For Office Use Only'

BCCF ID #: ____________________________

Received by: ______________ Date: _______ Reviewed by: ________ Date: __________

Disposition____

____

Breast Cancer
Care Foundation

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

I, the undersigned, hereby request and give permission to:

____

(Name and contact information of health care provider)

to release all medical information from the record of:

______________________	____________	_______--______--________
Name of Patient	**Date of Birth**	**Social Security Number**

To: **Breast Cancer Care Foundation**
P.O. Box 101081
Arlington, VA 22210
Phone: 703-707-9491
Fax: 703-991-3252

Information to be released:

All records of named patient's treatment including, but not limited to: correspondence; progress notes; nursing notes; name, address and phone number of next of kin or legal guardian; rehabilitation services assessment; minutes of interdisciplinary team meetings; individualized treatment plans; records of all medical diagnoses, diagnostic tests, and treatments.

The purpose of this disclosure is : Financial and social support

1. I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records.
2. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization.
3. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.
4. A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.
5. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

______________________	______________________	__________
Signature of Patient	**Print Name**	**Date**
______________________	______________________	__________
Signature of Legal Guardian/ Authorized Person	**Print Name/Relationship to Patient**	**Date**