Delaware Breast Cancer Coalition

Kent County Breast Cancer Assistance Fund Application

Name: **Date of Birth:**

Address:

Home Phone: **Cell Phone:**

Email Address:

Race
❑ African American/ Black
❑ Asian
❑ Native American
❑ Pacific Islander
❑ Caucasian/White
❑ Other:

Ethnicity
❑ Hispanic
❑ Non-Hispanic

Referred By:

Hospital/Cancer Center where you are receiving treatment:

Treating Physician's name and phone number:

Name, address and phone number of patient's employer:

MEDICAL INFORMATION

Diagnosis date:

Cancer Diagnosis: **Is this an initial diagnosis?**

Type: **Stage:**

Surgery: **Treatment:**

Are you in active treatment?

If yes, please specify which treatments you have received in the past six months and what future treatments you expect:

Type of health insurance?

Renewal Date:

Deductible (if applicable):

Co-pays (if applicable):

Personal Statement:

Please describe your financial situation and how your diagnosis and treatment has affected it and how your breast cancer diagnosis has caused you financial hardship.

FINANCIAL INFORMATION

Total number of working adults in the household:

Total number of adults in the household:

Number of children under 18 years in the household:

TOTAL HOUSEHOLD INCOME	**BEFORE DIAGNOSIS**	**AFTER DIAGNOSIS**
Salary		
Disability		
Social Security		
SSD		
Other		
Other		
Other		

EXPENSE INFORMATION: PLEASE PROVIDE YOUR MOST RECENT BILLS THAT APPLY

TYPE	**COMPANY**	**AMOUNT DUE**	**DUE DATE**	**RATE PRIORITY**	**BILL PROVIDED (Y/N)**
Cell Phone					
Electric					
Gas/Oil					
Water					
Rent or Mortgage					
Phone/Internet/ Cable					
Other Expenses (please list)					

Please Read the Following Carefully Before Signing:

The Kent County Breast Cancer Assistance Fund is an emergency fund established for the sole purpose of providing immediate assistance to residents of Kent County undergoing treatment for breast cancer. Residents of Kent County with a demonstrated financial need who are receiving treatment for breast cancer at Bayhealth Cancer Center or a Cancer Center located outside of Kent County may be eligible to receive funds.

This fund will provide emergency financial assistance for basic living expenses on behalf of breast cancer patients who have lost all or part of their income during active treatment. Basic living expenses considered include but are not limited to household bills such as rent, mortgage, utilities, phone, transportation, groceries, childcare, personal care or needs, respite care prostheses, wigs, lymphedema sleeves, genetic testing and medical expenses not covered by funds from the Cancer Center and other community agencies.

Guidelines:

1. Applicant must reside in Kent County Delaware, regardless of where they are receiving treatment.
2. Applicant must have a diagnosis of breast cancer and must be in active treatment when funds are requested. Active treatment is defined as the period after a positive diagnosis of breast cancer has been made and during which therapies are being administered, including surgical procedures, chemotherapy and radiation. Active treatment does not include long-term hormonal therapies. Also included are patients with metastatic breast cancer.
3. OR, Applicant must be a breast cancer survivor who can show financial need for assistance in paying for subsequent mammogram screenings and/or lymphedema garments, prosthesis and bras.
4. A confirmation of diagnosis and treatment must be provided by a member of the applicant's medical team.
5. Patient must be able to show a reduction or loss of income as a result of the breast cancer diagnosis.
6. Patient must show a clear financial hardship and the inability to meet current monthly living expenses.
7. No funds will be given directly to the patient or the patient's family. Payment will be made directly to the service provider or creditors

Accordingly, I hereby certify under penalty of perjury that the financial information set forth on this application concerning my annual personal income, assets, liabilities and insurance provider is true and accurate, that the expenses I have requested financial assistance for on my behalf impose a financial hardship to me; that I have been diagnosed with breast cancer and am currently undergoing treatment for breast cancer and that I do not have adequate insurance or income to pay for the expenses. I understand that if any of the information set forth above is false, my application will be null and void.

SIGNATURE:_____ DATE:_____

By signing above, I hereby grant and give permission for representatives of Delaware Breast Cancer Coalition, Inc. to contact my physician(s) as needed.

Delaware Breast Cancer Coalition
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