Delaware Breast Cancer Coalition

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 DBCC Breast Cancer Assistance Fund is an emergency fund established for the sole purpose of providing immediate assistance to residents of Delaware undergoing treatment for breast cancer. Residents of Delaware with a demonstrated financial need who are receiving treatment for breast cancer at any Delaware Cancer Center or a Cancer Center located outside of the state 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 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
Attn: Lois Wilkinson
165 Commerce Way, Suite 2
Dover, Delaware 19904
302-672-6435
lwilkinson@debreastcancer.org

DBCC Financial Assistance Program

1 of 3) HIPPA Authorization Form – Healthcare Provider/Physician/Facility

I, _____, *(Name of Nominee Patient)* hereby authorize _____ (Name of *Healthcare Provider/Physician/Facility)* to release and furnish to Delaware Breast Cancer Coalition copies of full and complete protected medical information, including the following:

- For use in the Delaware Breast Cancer Coalition Financial Assistance Program (the "Grant Program") . To my healthcare provider: This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me. It does not permit you to be interviewed, to give any statements or supply any narrative reports concerning your care and treatment of me.

- All medication records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.

- All autopsy, laboratory, histology, cytology, pathology, radiology, CT scan, MRI, echocardiogram and cardiac catheterization reports. All radiology films, mammograms, myelograms, CT scans, photographs, bone scans, pathology, cytology, histology, autopsy, immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____ *(Name of Healthcare Provider/Physician/Facility)*. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorizatio n. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above. This authorization does not apply to psychotherapy notes, psychiatric or psychological records. **A notarized signature is not required.** 45 CFR 164.508. A facsimile or copy of this authorization shall have the same force as an original.

Unless earlier revoked, this authorization shall expire in its entirety upon Delaware Breast Cancer Coalition's determination that I am ineligible for the Grant Program, or, if no such determination of ineligibility is made, upon Delaware Breast Cancer Coalition's final decision to grant or deny an award to me under the Grant Program.

_____ _____
Signature of Nominee Patient or Personal Representative Date

_____ _____
Name of Patient or Personal Representative Date

Description of Personal Representative's Authority to Sign for Patient *(attach documents which show authority)*:

_____

This authorization is valid only for records

from:_____

Name of Healthcare Provider/Physician/Facility

DBCC Financial Assistance Program

2 of 3) HIPPA Authorization Form – Nominator

I, _____, *(Name of Nominee Patient)* hereby authorize _____ (*the "Nominator*") to (i) review my health record and (ii) release and furnish to Delaware Breast Cancer Coalition certain protected medical information, including information regarding the diagnosis and treatment of me, solely for the purpose of completing the nomination forms for the Delaware Breast Cancer Coalition's Financial Assistance Program (the "Grant Program"). I understand that the Grant Program nomination forms require disclosure of certain medical information, and I hereby authorize and consent to the inclusion of such information in the nomination forms.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to _____ *(name of nominator)*. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the releaser indicated above. This authorization does not apply to psychotherapy notes, psychiatric or psychological records. **A notarized signature is <u>not</u> required.** 45 CFR 164.508. A facsimile or copy of this authorization shall have the same force as an original. Unless earlier revoked, this authorization shall expire in its entirety upon Delaware Breast Cancer Coalition's determination that I am ineligible for the Grant Program, or, if no such determination of ineligibility is made, upon Delaware Breast Cancer Coalition's final decision to grant or deny an award to me under the Grant Program.

_____ _____

Signature of Nominee Patient or Personal Representative Date

_____ _____

Name of Patient or Personal Representative Date

Description of Personal Representative's Authority to Sign for Patient *(attach documents which show authority)*:

_____

This authorization is valid only for information provided by:

_____

Name of Nominator

[End of HIPAA Authorization Form]

DBCC Financial Assistance Program

3 of 3) Authorization Form – Personal Story

I, _____, *(Name of Nominee)* understand that (i) certain information about me, including but not limited to my age, diagnosis and a description of the effect that my diagnosis has had on me and my family (my "Personal Story"), will be shared with Delaware Breast Cancer Coalition in connection with the DBCC Financial Assistance Grant Application, (ii) if I am awarded a grant under the DBCC Financial Assistance Program (the "Grant Program"), DBCC may wish to share my Personal Story or any part thereof (a) with the donor who supported the grant made to me, and/or (b) on DBCC's website and social media websites and applications, including Twitter, Facebook and Instagram ("Online Uses"), (iii) my Personal Story will **not** be shared with any third party **unless** I select one of the options listed below and (iv) my eligibility for a grant under the Grant Program will not be affected by my decision to select or not select any of the options listed below.

I hereby authorize DBCC to share my Personal Story as follows:

DBCC may share my Personal Story, including my first name but not my last name, with third parties, including Online Uses. DBCC may share my Personal Story but **not** my name, with third parties, including Online Uses.

DBCC may share my Personal Story, including my first name but not my last name, with third parties, excluding Online Uses. DBCC may not share my Personal Story or my name, with third parties

_____ _____

Signature of Nominee Date

Name of Nominee