



Delaware Breast Cancer Coalition's
Breast Cancer Assistance Fund Application

Name:

Date of Birth:

Address:

Home Phone:

Cell Phone:

Email Address:

Pronouns Preferred:

Race:

☐ African American/Black

☐ Asian

☐ Native American

☐ Caucasian/White

☐ Other:

Ethnicity:

☐ Hispanic

☐ Non-Hispanic

☐ Haitian

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:

Breast 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, how your diagnosis and treatment has affected it, and how your breast cancer diagnosis has caused you financial hardship. Continue writing on the back of this page if needed.



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/or other community agencies.

Guidelines:

1. Applicants must reside in Delaware, regardless of where they are receiving treatment.
2. Applicants 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. Patients with metastatic breast cancer may be included throughout their diagnosis with eligible expenses.
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. Patients must be able to show a reduction or loss of income as a result of the breast cancer diagnosis.
6. Patients must show 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 the above, I hereby grant and give permission to representatives of Delaware Breast Cancer Coalition, Inc., to contact my physician(s) as needed.

Delaware Breast Cancer Coalition Attn: Meridith Rothstein
18977 Munchy Branch Road, Rehoboth Beach, DE 19971
302-212-2947 Ext 1032 | mrothstein@debreastcancer.org
FAX: (302) 672-7834



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 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 authorization. I need not sign this form to ensure 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 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) HIPAA 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 to ensure 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 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 information provided by: _____

Name of Nominator

[End of HIPAA Authorization Form]

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DBCC Financial Assistance Program: 3 of 3) HIPPA 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 the Delaware Breast Cancer Coalition (DBCC) 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 (collectively referred to as “third parties”).

(iii) My Personal Story will **not** be shared with any third party **unless** I select one of the options listed below.

(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 (please check one):

_____ The Delaware Breast Cancer Coalition (DBCC) may share my first name only with my Personal Story with third parties.

_____ The Delaware Breast Cancer Coalition (DBCC) may share my Personal Story but not my name with third parties.

_____ The Delaware Breast Cancer Coalition (DBCC) may not share my Personal Story nor my name with third parties.

Signature of Nominee

Date

Name of Nominee Printed

Date

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