BREAST CANCER SOLUTIONS

Mailing Address: 3843 S. Bristol Street #152, Santa Ana, CA 92704-7426
phone: 866.960.9222 fax: 866.781.6068 website: www.breastcancersolutions.org

CLIENT APPLICATION

BCS provides support for individuals living in Orange County, San Diego County, and Inland Empire who are going through breast cancer treatment, and whose income and/or expenses are significantly impacted by treatment for breast cancer. If you have completed surgery, chemotherapy, and/or radiation for primary breast cancer, are considered to have no evidence of disease (NED), and are now taking adjuvant Tamoxifen, Arimidex or similar hormonal treatment on a long-term basis, you are no longer considered to be in treatment for active breast cancer and are no longer eligible for assistance. If you stop treatment for any reason against your oncologist's advice, you will no longer be eligible for assistance. **BCS reserves the right to verify income, expenses, and treatment plan by requesting the following information.**

VERIFICATION	CONDITIONS
Identification	Must provide proof of identification. Picture ID, CDL, California ID, passport, employment or school ID, or other acceptable identification and social security card, if available.
Housing	Must be a resident of Orange, San Diego, Riverside, or San Bernardino counties to be eligible for BCS support. Proof of location of residence by rent receipt, mortgage payment receipt or contract, or note from landlord; utility receipts, turn-off notice, late notice, eviction notice, fore-closure notice, 3 day notice to quit, etc.
Income	Must provide verifiable income information for pre-treatment and during treatment. Earned and unearned income for spouse or other responsible persons living in the home must be included.
Medical statement	Must be in active treatment to receive BCS support. Current diagnosis, prognosis, surgery date, and treatment plan with date and signature of treating physician.
Real estate	Must provide information about owned property including rental real estate, second homes, etc.
Non-shelter expenses	Must provide information about credit card payments, car payments, child care, child support, cable, furniture storage, health club, other legal obligations for spouse or other responsible persons living in the home.
Vehicles	Exempt.
Liquid resources	Must demonstrate that available liquid resources are below $1,000 total limit; includes bank accounts, stocks, bonds and any other accessible items that can be readily converted. Inaccessible resources are exempt, such as 401k, IRAs, etc.
Personal items	Exempt.

Complete pages 1-2 of the application. Page 3 contains an authorization for release of your medical information by your doctor. Fill this form out completely, and ask your doctor's office (oncologist, surgeon - whomever you consider to be the head of your medical team) to make a copy. This form tells your doctor that you give him/her permission to provide information about you to BCS and should be kept in your chart. Enter your name and date of birth in Section I of page 4, and have your physician complete page 4, which will tell BCS about your breast cancer diagnosis and treatment plan. S/he should complete the form, attach pertinent pathology documentation, and may return it to you or mail or fax it directly to BCS. Please see the address, phone and fax numbers above.

Please note: Your application will not be processed until BCS has received all 4 pages, including the physician report (page 4). In order to complete the application process, you will be asked to interview with two BCS Client Support Volunteers.

*****Please initial the bottom of every page of this application*****

Date of Application ____

Name: ____ Date of Birth: ______________________________

Address: ____

City, State Zip: ____

Phone number: Home: ____ Work: ____________________________________

Cell Phone: ____ Fax: _____________________________________

Ethnicity (optional): ____ Preferred Language: __________________________

Marital Status: _______________ Do you have children living at home? _______________ Number of children: _______________

(Age/Gender) & names of children: (/) _________ (/) _______________ (/) _______________ (/) _______________

Emergency Contact name: _________________________ Relationship: ________________ Phone: __________________________

Full disclosure is needed for your application to be considered

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Applicant Initials ___________

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How much was your income before breast cancer treatment? _________ How much were your expenses before treatment? __________

How much is your current income? ______________________________ How much are your current expenses? ___________________

Why have your income and/or expenses changed during treatment? ____

Did someone help you with this application? ☐ No ☐ Yes

Name: ____ Relationship: _____________________________________

Phone Number: ____ Email:____

What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, Medi-Medi, None) ______________________

CURRENT INCOME	**Monthly amount**
1. Your wages/salary *if you are currently working* (after taxes)	1. $
2. Spouse/partner's wages/salary (after taxes)	2. $
3. Property rental income	3. $
4. Interest/dividends	4. $
5. Veterans Benefits	5. $
6. Roommate/Boarder	6. $
7. Disability (circle one through state through employer)	7. $
8. SSI/SSD	8. $
9. Unemployment Insurance	9. $
10. Other	10. $
11. Other	11. $
12. Other	12. $
TOTAL OF ALL MONTHLY INCOME (Add lines 1 through 12 together):	**$**

Please use the Other lines to indicate if you are receiving other Social Security benefits, pension or retirement benefits, Worker's Compensation, child support/alimony, care of foster child, in-home care/in-home supportive services benefits, school grants/loans, general relief (Welfare), food stamps, CalWORKS (AFDC) or any other form of support.

MONTHLY EXPENSES	**Monthly Amount**
1. ☐ Mortgage or ☐ Rent Equity owned in Home $_______________	1. $
2. Gas __________ Electricity __________ Water __________ Trash _________ Cable __________	2. $ (total)
3. Telephone and/or cellular phone	3. $
4. Food	4. $
5. Auto Loan __________ Auto Insurance __________ Gasoline ___________	5. $ (total)
6. Medications (related to breast cancer treatment only)	6. $
7. Medical co-payments and/or share of cost of breast cancer treatment	7. $
8. Health insurance premiums	8. $
9. Other:	9. $
10. Other:	10. $
TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 10 together):	**$**

☐ Please check this box if applicant would like to be referred to other agencies for possible assistance. Referrals may result in sharing applicant's information between BCS and other agencies.

By signing below, I agree that the above information is true and correct.

_______________________________________ Applicant Signature

_______________ Date

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APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: ____

Doctor or Medical Group **From Whom** Information is Requested (e.g., your oncologist)

Address: ____

____

____

____

I, ______________________, residing at ______________________________

____

____

hereby authorize you to release to Breast Cancer Solutions non-profit organization (33-0765783) specific information requested by them which I cannot provide concerning:

____

____

____

____

This information is needed to determine my eligibility for assistance from Breast Cancer Solutions (BCS). I have read this form and have agreed to its request prior to my signing.

Print name	Social Security Number (Optional)
Date of birth	Birthplace
Signature of Applicant	Date
Signature of Witness	Date

Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Breast Cancer Solutions.

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PHYSICIAN'S REPORT

The individual listed below has requested assistance from Breast Cancer Solutions (BCS) and has stated that s/he is unable to work or is unable to work at pre-treatment level. A signed release for the requested information is attached.

Please complete this form and return it by: ____________ (date)

Attn: Director of Client Services
Breast Cancer Solutions
3843 S. Bristol Street #152
Santa Ana, CA 92704-7426

Phone: 866.960.9222

Fax: 866.781.6068

SECTION I			
Patient Name:			
Patient Date of Birth:			Patient ID # (optional):
Physician's Name:			Physician's phone:
Physician's Address:			Physician's fax:
SECTION II – TO BE COMPLETED BY YOUR PHYSICIAN			
Diagnosis:			
Stage:		Grade:	
Date of diagnosis:		Date of last appointment:	
Pertinent pathology results (please attach copy of pathology report):			
Medications prescribed:			
Indicate client's prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Other:			
Specific physical limitations:			
What level of employment activity is suitable for patient? ☐ Part-time ____ hours per week ☐ Full-time			
Projected date patient can return to work at pre-treatment level:			

Planned surgeries	Date of procedure	Expected recovery date
Other Planned Treatments (chemo, radiation, etc.)	**Start date**	**Expected end date**

Comments:	
Physician's signature:	Date Signed:

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