Breast Cancer Solutions

(866) 960-9222 (phone)
(866) 781-6068 (fax)
bcsfax@onebox.com (email; no image files)

FINANCIAL ASSISTANCE APPLICATION

Eligibility for financial assistance:

- **Resident of Orange, San Bernardino, or Riverside Counties (California).**
- In active treatment (surgery, chemotherapy, or radiation to treat breast cancer) with a board certified/licensed oncology team.
- Experiencing financial hardship because of breast cancer treatment.

BCS does not provide financial assistance if you:

- Are considered to have no evidence of disease.
- Are taking a long-term hormonal treatment/inhibitor only (e.g., Tamoxifen) for stage I, II, or III cancer.
- Are receiving hospice care only.
- Are undergoing reconstruction but not any other treatment.
- Stop treatment against doctor's advice.
- Have over $6,000 in savings/liquid assets.

Instructions: Complete pages 1 and 2, sign page 3, and fill out top of page 4. See page 4 for medical verification instructions. Application will be reviewed once all pages are received by Breast Cancer Solutions (BCS).

PART 1: APPLICANT INFORMATION

Name: _____ Date of Birth: _____

Address: _____ Apt/Unit # _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Preferred Language: _____

Email: _____ Ethnicity (optional): _____

Marital Status: _____ Number of children age 0-17 / 18+: _____ / _____

Social worker name (if applicable): _____ Phone: _____

What medical insurance do you have?

☐ Medicare ☐ Medi-Cal ☐ BCCTP ☐ Affordable Care Act/Covered California

☐ Private HMO (specify): _____ ☐ Private PPO (specify): _____ ☐ None

PART 2: INTAKE QUESTIONS

1. How did you hear about BCS? _____
2. What expenses concern you most at this time (check all that apply)? ☐ Housing ☐ Food ☐ Transportation/Gas ☐ Medical Costs ☐ Utilities ☐ Other: _____
3. Have you had to postpone or skip any of your scheduled treatment appointments? ☐ YES ☐ NO
   If YES, please explain why: _____
4. Please rate your experience with BCS using the following scale:
   4 – Strongly Agree 3 – Agree 2 – Disagree 1 - Strongly Disagree N/A – Not applicable

   a. It was easy for me to get a financial assistance application: _____
   b. BCS staff answered my questions thoroughly: _____
   c. BCS staff was professional and courteous: _____
   d. The referrals I received were helpful to me: _____

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PART 3: FINANCIAL INFORMATION

YOUR CURRENT EMPLOYMENT STATUS

☐Full Time ☐Part Time ☐Unemployed ☐Retired ☐Not working ☐Not working due to treatment

CURRENT MONTHLY HOUSEHOLD INCOME

Please list all sources of income, including your wages/salary, spouse/partner wages/salary, pension, social security, rental income, alimony, child support, disability, unemployment, SNAP/EBT, Veteran's benefits, etc.

Income Source	**Amount**
1.	$
2.	$
3.	$
4.	$
5.	$
TOTAL	**$**

What has changed with your income since starting breast cancer treatment?_____

_____

If applicable, how much do you have in savings?_____

CURRENT MONTHLY HOUSEHOLD EXPENSES

Monthly Expense	**Amount**
1. Rent/Mortgage	$
2. Phone	$
3. Electric/Gas/Cable	$
4. Water/Trash	$
5. Food/Household Items	$
6. Auto Loan	$
7. Auto Insurance	$
8. Gasoline	$
9. Medications (related to breast cancer treatment only)	$
10. Medical co-payments and/or share of cost of breast cancer treatment	$
11. Health insurance premiums	$
12. Other:	$
TOTAL	**$**

What expenses have changed since starting breast cancer treatment?_____

_____

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PART 4: POLICIES AND PROCEDURES

- Financial assistance is not always available. Please see our website for most current updates.
- BCS is not responsible for any fees accrued because of late payments or termination of services. We do not reimburse for bills already paid. BCS must have the most recent statements prior to paying any utility bills; amount due is subject to verification. BCS reserves the right to request information or documents to verify income and expenses.
- BCS reserves the right to refuse service to anyone. Financial assistance is not guaranteed. If any information submitted in your application or interview is found to be not truthful, your request for financial assistance will be denied and/or any approved assistance will end immediately. As a registered non-profit organization, we must strictly follow the guidelines set forth by our Board of Directors.
- BCS does not permit the use of the organization's name or logo without permission.

By signing below, or by inserting a typed or digital signature, I agree that the information I have provided in this application is true and correct, and I will adhere to the stated policies and procedures.

_____ _____

Signature Date

_____

Printed name

☐ Check if you would like referrals to other resources (if checked, your information may be shared)

SUBMIT YOUR COMPLETED APPLICATION TO BREAST CANCER SOLUTIONS

Mail: Breast Cancer Solutions, 25422 Trabuco Rd. #105-167, Lake Forest, CA 92630
Email: bcsfax@onebox.com (no image files please; do not use any other email address)
Fax: 866-781-6068

Breast Cancer Solutions does not discriminate on the basis of race, ethnicity, color, religion, sexual orientation, sex, gender, gender identification, national origin, citizenship, veteran status, ancestry, age, physical or mental disability, or any other protected class or group.

Additional Comments:

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PART 5: MEDICAL VERIFICATION

For applicant to complete

I hereby authorize you to release to Breast Cancer Solutions (BCS) (nonprofit ID 33-0765783) the following information concerning my breast cancer treatment:

- Most recent pathology report;
- Breast cancer diagnosis, including date, stage, grade, type, ER/PR status, her2 status;
- Treatment plan: Projected date(s) for surgery, chemotherapy start/end dates and medications, radiation start/end dates, and/or oral treatment medications.

Patient Name:	Patient Signature:
Patient Address:	Patient Date of Birth:

This information may be provided via medical records or by completing the form below to verify eligibility for assistance from BCS. Pathology report is required either way. I have read this form and agree to its request. *BCS reserves the right to request additional verification information if needed.*

*****FOR PHYSICIAN TO COMPLETE*****

Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:

Diagnosis:					
Stage:	Grade:	Triple negative: Y or N	Her2 Positive: Y or N	ER+ ? Y or N	PR+ ? Y or N

Date of diagnosis:	Date of last appointment:	
Surgery (specify type)	Date of procedure	Expected recovery time
Chemotherapy (specify medications)	Start date	Expected end date
Herceptin	Start date	Expected end date
Radiation	Start date	Expected end date

Client's prognosis: ☐ Good ☐ Fair ☐ Guarded ☐ Other:

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:

Other prescribed medications:

Comments:

****Send pathology report and this form or records to Breast Cancer Solutions****

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