

## FINANCIAL ASSISTANCE APPLICATION

**Eligibility for financial assistance:**

- **Resident of Orange, San Bernardino, or Riverside Counties (California).**
- Your current household annual income must be at or below 300% Federal Poverty Level.
- In active treatment (surgery, chemotherapy, or radiation to treat **breast cancer**) with a board certified/licensed oncology team.
- Financial hardship due to 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: \_\_\_\_\_

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 ONE expense concerns you most at this time (check one)?  
 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: \_\_\_\_\_

### 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.	\$
<b>TOTAL</b>	<b>\$</b>

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:	\$
<b>TOTAL</b>	<b>\$</b>

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:** application@breastcancersolutions.org (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:**

**PART 5: MEDICAL VERIFICATION**

**This form and current pathology report are required for this application to be processed**

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:

**\*\*\*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: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Guarded <input type="checkbox"/> Other:					
What level of employment activity is suitable for patient? <input type="checkbox"/> Part-time ____ hours per week <input type="checkbox"/> Full-time					
Projected date patient can return to work at pre-treatment level:					
Other prescribed medications:					
Comments:					

**\*\*Send pathology report and this completed form to Breast Cancer Solutions\*\***

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