Breast Cancer Solutions

Mailing Address: 25422 Trabuco Road #105-167, Lake Forest, CA 92630-2797
866.960.9222 (phone) ◆ 866.781.6068 (fax) ◆ www.breastcancersolutions.org

APPLICATION FOR FINANCIAL ASSISTANCE

ELIGIBILITY:	**BCS provides support for individuals who are going through active breast cancer treatment who are experiencing financial hardship as a direct result of their treatment.** Active treatment means you have an upcoming surgery, chemotherapy, or radiation to treat primary breast cancer. **APPLICANTS FOR FINANICAL ASSISTANCE MUST RESIDE IN ORANGE, SAN BERNARDINO OR RIVERSIDE (CALIFORNIA) COUNTIES.** Please visit our website for resources in other areas. BCS does not provide assistance if you: • Are considered to have no evidence of disease (NED); and/or • Are taking a long-term hormonal treatment only (e.g., Tamoxifen) for stage I, II, or III cancer; and/or • Are receiving hospice/palliative care only; and/or • Are in the process of undergoing reconstruction but not receiving any other treatment; and/or • Stop treatment for any reason against your doctor's advice; and/or • Have over $6,000 in liquid assets (does NOT include 401Ks, IRAs, vehicles or personal items)

DIRECTIONS:

- ☐ Fill out pages 1-4 of this application. Fax or mail those pages to BCS.
- ☐ Fill out page 5, and the top of page 6. Give BOTH pages to your doctor.
- ☐ After your doctor completes page 6, ask him/her to fax or mail **page 5, page 6 and your pathology report** to BCS.
- ☐ We will contact you once we have received your completed application (including the report from your doctor). **Your application will not be processed until we have all 6 pages.**
- ☐ Every page of the application must be completed.

Date of Application _____ **How did you hear about BCS?**_____

CONTACT INFORMATION

Name: _____ Date of Birth: _____

Mailing Address: _____
street address city state zip code

Home phone: _____

Cell Phone: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell phone: _____

Did someone help you with this application? ☐ No ☐ Yes Name: _____

Relationship: _____ Phone: _____

What medical insurance do you have (circle)? Medicare MediCal BCCTP Medi-Medi None

Affordable Care Act/Covered California Private (specify): _____HMO/PPO (circle one)

Ethnicity (optional): _____ Preferred Language: _____

Marital Status: _____ Number of minor children living at home: _____

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HOUSEHOLD INCOME – *Full disclosure is required*	**Monthly Amount Before Diagnosis**	**Monthly Amount - Current**
1. Your wages/salary *if you are currently working* (after taxes)	1.	1.
2. Spouse/partner's wages/salary (after taxes)	2.	2.
3. Income from other contributing household member(s)	3.	3.
4. Roommate/Boarder	4.	4.
5. Disability (please circle) Accepted Pending Denied Date of application:	5.	5.
6. SSI/SSD (please circle) Accepted Pending Denied Date of application:	6.	6.
7. Social Security (please circle) Accepted Pending Denied Date of application:	7.	7.
8. Food Stamps (please circle) Accepted Pending Denied Date of application:	8.	8.
9. General Relief/Welfare (please circle) Accepted Pending Denied Date of application:	9.	9.
10. Unemployment Insurance (please circle) Accepted Pending Denied Date of application:	10.	10.
11. Child support/alimony	11.	11.
12. Other*	12.	12.
13. Other*	13.	13.
TOTAL OF ALL MONTHLY INCOME (Add lines 1 through 13):	**$**	**$**

*Examples: Non-profit assistance agencies, Veterans benefits, pension/retirement, rental property income, worker's compensation, interest/dividends, foster child support income, in-home care/in-home supportive services benefits, school grants/loans, or CalWORKS (AFDC). Financial assistance from other agencies **does not disqualify you** from receiving support from BCS.

MONTHLY EXPENSES – *Full disclosure is required*	**Monthly Amount Before Diagnosis**	**Monthly Amount - Current**
1. ☐ Mortgage or ☐ Rent	1.	1.
2. Gas _____ Electricity _____ Water _____ Trash _____ Cable _____	2. (total amount)	2. (total amount)
3. Telephone (land line) _____ Cellular phone _____	3. (total amount)	3. (total amount)
4. Food and household items (e.g., cleaning supplies, sundries)	4.	4.
5. Auto Loan _____ Auto Insurance _____ Gasoline _____	5. (total amount)	5. (total amount)
6. Medications (related to breast cancer treatment only)	6.	6.
7. Medical co-payments and/or share of cost of breast cancer treatment	7.	7.
8. Health insurance premiums	8.	8.
9. Other:	9.	9.
10. Other:	10.	10.
TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 10):	**$**	**$**

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

_____

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

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Intake Evaluation

BCS gathers the following information to help train staff and volunteers to best serve our clients. While we require that you answer the following questions, please know that **your responses will in no way impact whether or not you receive assistance from BCS, or how much you receive**. We ask only that you answer these questions truthfully so that we can strengthen any areas of weakness.

1. How did you hear about BCS? (Please circle your answer)

BCS Website	Friend/Word of Mouth	Susan G. Komen
Doctor's Office/Treatment Center Please specify:	Support Group Please specify:	American Cancer Society
Other Nonprofit Agency or Foundation Please specify:	Facebook/Twitter	Online/Website Other Than BCS Please specify:
Other Please specify:		

2. 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. My BCS application was mailed to me in a timely manner.	
b. I was able to locate and download the application form on the BCS website easily.	

Please answer questions c-e ONLY if you have spoken with a BCS staff member or volunteer.

c. My questions were answered thoroughly.	
d. BCS staff and volunteers were consistently courteous and friendly.	
e. The referrals I received were helpful for my personal situation.	

Please feel free to explain any of the above ratings:

3. Please circle the types of assistance you need at this time (circle all that apply):

Food/groceries assistance	Utilities assistance	Housing assistance: rent / mortgage	Government programs (e.g., SSI, SSD)
Transportation (circle all that apply): gas cards bus passes other	Support groups	Social support (other than support groups)	Legal resources or assistance
Treatment assistance (circle all that apply): Medication costs co-payments insurance premiums		Counseling (circle all that apply): Individual Couples Family	
Other:			

4. Have you had to postpone or skip any of your scheduled treatment appointments? (please circle) YES NO

If YES, please explain why:

5. What household expenses concern you most at this time?

6. If you are a returning client, why are you re-applying for assistance?

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Policies and Procedures

1. **APPLICANTS FOR FINANICAL ASSISTANCE MUST RESIDE IN ORANGE, SAN BERNARDINO OR RIVERSIDE (CALIFORNIA) COUNTIES.**
2. BCS is not responsible for any fees accrued because of late payments or termination of services.
3. BCS does not reimburse for any bills already paid by the applicant.
4. BCS must have the most recent statements prior to paying any utility bills. BCS will verify the amount due, when possible, prior to paying utility bills.
5. BCS will not pay for services that are reimbursable by insurance companies.
6. BCS does not permit the use of the organization's name or logo without permission.
7. 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.
8. BCS reserves the right to refuse service to anyone.

Eligibility Verification

BCS reserves the right to request the following:

- Proof of Identification (proof of immigration status is NOT required)
- Housing
- Income
- Real estate
- Non-shelter expenses
- Liquid resources

By signing below, 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 agencies (if checked, your information may be shared with those agencies)

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APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: _____
Doctor, Medical Group or Agency Name

Address: _____

_____

_____

Phone: _____

I, _____, residing at _____
(your name) (your address)

_____

hereby authorize you to release to Breast Cancer Solutions non-profit organization (33-0765783) specific information requested by them which I cannot provide concerning my breast health and/or breast cancer treatment.

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

_____ _____
Print Name Date

_____ _____
Signature of Applicant Date of Birth

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). **This form and a copy of the pathology report are required for this patient's application to be considered complete.** A signed release for the requested information is attached.

Attn: Breast Cancer Solutions
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Fax: 866.781.6068

SECTION I – TO BE COMPLETED BY APPLICANT	
Patient Name:	
Patient Date of Birth:	
Physician's Name:	Physician's phone:
Physician's Address:	Physician's fax:

SECTION II – TO BE COMPLETED BY PHYSICIAN – PLEASE PRINT CLEARLY			
Diagnosis:			
Stage:	Grade:	H2N Positive (circle): Y or N	Triple Negative (circle): Y or N
Date of diagnosis:		Date of last appointment:	

Planned Treatments		
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:
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:
Other prescribed medications:
Comments:

☐ **Copy of patient's pathology report is attached to this report**	
Physician's signature:	Date: