12916 Conamar Dr., Suite 201
Hagerstown, MD 21742
301-791-5843
FAX 301-797-4090
Email info@bcacv.org

*Breast Cancer Support Organization* *Serving MD, PA, & WV*

# Application for Special Needs Assistance – Confidential

To be considered for assistance from Breast Cancer Awareness, Inc. (hereinafter BCA), ***please complete all sections and make sure all required signatures are included.***

- **Special Needs Assistance is available to breast cancer patients who are actively undergoing chemotherapy and radiation treatments.**
- **Completed application – Remember to include your signature on the last page and have your physician complete and sign it.**
- **A copy of your most recent income tax form**
- **Original bills for consideration**

**Send Complete Application packet to:**
**Breast Cancer Awareness, Inc**
**Attention: Executive Director**
**12916 Conamar Drive, Suite 201,**
**Hagerstown, MD 21742**

The Special Needs Assistance Program is for help with financial costs for basic living expenses. No medical/prescription bills will be considered.

Participant's Name:

_____
First Middle

_____
Last

Date of Birth: _____/_____/_____

Name of Spouse: _____

Home Address: _____

_____
City State Zip

Home Phone: _____ Work Phone: _____

Best time to call: ____ morning _____ evening _____ anytime

Email Address: _____

Breast Cancer Awareness, Inc. strives through total community involvement to decrease the impact of breast cancer and promote early detection in all individuals through information, empowerment, and peer support, so that no one faces breast cancer alone.

## Personal and Family Information

Marital Status (check one) _____ Single _____ Married _____ Widowed _____ Partnered

_____ Separated _____ Divorced

How many persons are living in your household? _____ (including yourself, all adults and children)

Ages of Children: _____

Do you rent or own your home? _____ Rent _____ Own

Are you currently employed? _____ Name of Employer_____

Spouse's Employer: _____

Do you have health insurance? _____ Private/Employer Insurance

Level of deductible $_____Medicaid _____ Medicare _____ Disability Insurance

_____ None_____

Public or private assistance you are receiving: _____

Total after tax household income per year (including **all** persons living in household):_____

Are you currently receiving financial assistance from other organizations? _____YES _____NO

If YES, indicate the names of the organizations and the amounts of assistance you have received.

_____

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## Needs Assessment

If you were able to prioritize your current needs, please choose the one that is most critical from the list below:

_____ Housing – rent or mortgage payment

_____ Transportation Service – needed for chemotherapy/radiation treatment – doctor's appointments

_____ Utility/Telephone bill payment

_____ Nutrition assistance or food assistance

_____ Cleaning or household goods

_____ Other (please explain) _____

_____

Payments to third parties (i.e., rent, mortgage, utilities, phone bills, etc.) are made directly to the third party.

Please supply third party information below together with copy of invoice.

Name of company_____

Address: _____

Phone: _____ Contact person: _____

Account number associated with this payment: _____

Please give a brief explanation how you would like us to help you:

Please read and sign below. Make sure to have your signature witnessed and dated.

- I understand and agree that no promises or assurances whatsoever have been made to me by any representative of BCA regarding the assistance I am requesting.
- I understand and grant my permission to all doctors, clinics and hospitals to provide information to BCA relating to treatment and care for breast cancer and other related health problems when necessary. BCA agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission.
- I understand and agree that fulfillment of assistance may result in publicity not authorized by BCA.
- I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by BCA.
- I acknowledge that there is a limit to the number of services that I will receive, depending on the type and cost of service being requested and offered.

Witness Date Participant Date

Spouse (if participant is unable to complete) Date

Amount Requested: _____

**Special Need Physicians Acknowledgement of Treatment**

****Complete and return to BCA office.**

Breast Cancer Awareness, Inc.
12916 Conamar Drive, Suite 201
Hagerstown, MD 21742

Dear BCA:

I, _____ (patient name) authorize the release of the information contained herein to Breast Cancer Awareness, Inc (BCA) as acknowledged by my signature below.

This information is to be used for the sole purpose of confirming treatment of breast cancer in order to receive assistance from BCA's Special Needs Program.

_____ _____
Patient's Signature Date

_____ _____
Patient's Name (printed) DOB

_____
Address

_____
Phone Number

* * * * * * * * * * * * * * * * * * * * * * * * * * * * *

**Physician to complete the following:**

This letter is intended to serve as confirmation that

_____ (patient name) is under my care for breast cancer and is currently receiving chemotherapy and/or radiation treatment for this condition.

Sincerely,

_____ _____
Physician's Signature Date

_____
Physician's Name (printed)

_____
Name of Practice

_____
Address

_____
Phone Number

Sincerely,
Stacy Horst
Executive Director