



CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE

www.jdbcfoundation.org

216-791-9447

Applicant Name: _____

GUIDELINES

- JD Breast Cancer Foundation is a non-profit 501(c)(3) tax-exempt organization committed to helping women and families affected by breast cancer. All applications will be evaluated on a non-discriminatory basis with no regard to age, race, ethnicity, or creed.
- Residents of Northeast Ohio (22 counties in the Northeast Ohio Komen Affiliate) are eligible for assistance.
- An applicant must be in active treatment (breast cancer surgery, chemotherapy, radiation, Hormonal) or have completed active treatment within the last 12 months.
- Applicants are eligible to apply for financial assistance after 12 months if they continue to be in active treatment.
- An individual may submit an application once every 12 months. Application submission does not assure assistance will be granted.
- Funds are limited and based upon availability and applicant's needs.
- Type and amount of assistance will be determined on a case by case basis by the JD Breast Cancer Foundation Financial Aid Review Committee.
- Applicants will receive a response by mail within 30 days upon receipt of the application AND required financial documents.
- All information is held in the strictest confidence and is used only by the JD Breast Cancer Foundation for the purpose of reviewing financial assistance needs.

INSTRUCTIONS (PLEASE NOTE: PROPER DOCUMENTATION IS REQUIRED TO COMPLETE THE APPLICATION PROCESS. INCOMPLETE APPLICATIONS WILL DELAY PROCESSING:

- Answer each question or indicate if an item does not apply to your situation
- Sign and date the application
- Have your ***Oncology physician's office*** complete the Medical Information section. This section may be completed by the physician, nurse, or social worker.
- Submit copies of any applicable statements or invoices.
- If requesting housing assistance, applicant must submit a copy of the mortgage statement, rental agreement or statement from your landlord.
- Submit copies of any applicable utility bills. All documents submitted must be ***the most recent (within 30 days)***, show the account information, Company Name, Mailing Address and phone number.
- Provide a phone number where you can be reached to answer any additional questions.

Please return this application to:

**JD Breast Cancer Foundation
Attn: Review Committee
10819 Magnolia Drive
Cleveland, OH 44106
Fax: 216.916.4466**

JD Breast Cancer Foundation's mission is to provide essential services to young women with breast cancer by offering financial assistance, emotional support, and education to enhance survivorship.



Some of the assistance available from JD Breast Cancer Foundation has been made possible through a grant from the Northeast Ohio Affiliate of Susan G. Komen For the Cure. The Komen name and logo are licensed marks of the Susan G. Komen For the Cure and are used solely to acknowledge the Komen Affiliate's grant.



Applicant Name: _____

DEMOGRAPHIC INFORMATION

Applicant's Full Name: _____ Date: _____

Social Security: _____

Address: _____ Age: _____ Date of Birth: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: Home () _____ Work: () _____

Cell: () _____ Email: _____

Race/Ethnicity (for data collection purposes only): _____

Marital Status: ___Single ___Married ___Widowed ___Separated ___Divorced

Spouse's Full Name: _____

(If legally married, spouse name must be indicated here. Separations or other circumstances may be explained in Biography section.)

Number of people living in household: Adults _____ Children _____

List Names & Ages of Adults/Children living in Household:

Do you rent or own this home? Rent Own Other

Referred to JD Breast Cancer Foundation by: _____

Have you previously received assistance from our Foundation? Yes No

If yes: Date: _____ Assistance Provided: _____

Have you received financial assistance from a similar cancer foundation?

If yes: Date: _____ Assistance Provided: _____

Do you currently have an application for assistance pending with another cancer Foundation

Yes No If yes, Name of Foundation: _____

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Applicant Name: _____

EMPLOYMENT STATUS (List employment information for all individuals contributing to household income):

Applicant Employer/Occupation:

Employer Address: _____

Employment Status (full-time, part-time, unemployed, FMLA, retired, disability, etc.): _____

Monthly Income (include pension, social security, disability, alimony, etc.): _____

Spouse Employer/Occupation (if applicable):

Employer Address: _____

Employment Status (full-time, part-time, unemployed, FMLA, retired, disability, etc.): _____

Monthly Income (include pension, social security, disability, alimony, etc.): _____

Other Adult Persons Employer/Occupation: _____

Relationship to applicant: _____

Employer Address: _____

Employment Status (full-time, part-time, unemployed, FMLA, retired, disability, etc.): _____

Monthly Income (include pension, social security, disability, alimony, etc.): _____

FINANCIAL INFORMATION

Total Household Monthly Gross Income from all adult sources living in your household (Pension, SSI, SSD, alimony, child support)	\$
<i>What is the Net Monthly Take Home Pay (from all adult sources living in the household)</i>	\$
<i>If Receiving food stamps, state total amount received</i>	\$
Total Household Liquid Assets (Cash on hand, checking or savings balance, money market, CD's, stocks)	\$
<i>Total Monthly Expenses (Housing, utilities, childcare, food, transportation, medical bills, etc.)</i>	\$

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INSURANCE / PRESCRIPTION INFORMATION

Type of health insurance: (please check all that apply)

- Private Health Insurance Provider (i.e. Medical Mutual, Kaiser, etc.)
- Medicare plus Medicaid
- Medicaid
- Medicare plus other supplemental coverage
- Medicaid Pending
- Disability
- Other _____
- None

Are prescription drugs covered? Yes No **Name of primary insured:** _____

Are co-pays covered? Yes No **If not, what is out-of-pocket expense:** _____

ASSISTANCE REQUEST

- For what purpose are you seeking financial assistance?**
- Food Costs
 - Transportation
 - Home Care
 - Prescription Assistance
 - Post surgical products (prosthesis, bra's, sleeves, gauntlets)
 - Housing Costs
 - Utility Costs
 - Other _____

- Documents submitted:**
- Gas Bill
 - Electric Bill
 - Phone Bill
 - Mortgage/Rent Statement
 - Invoice for Post Surgical Products
 - Transportation costs
 - Other _____
 - Invoice for Prescription costs & copy of written prescription
- Name of Pharmacy:** _____
Address: _____
Phone number: _____

- What other cancer services are you interested in?**
- Support Groups/List Group Focus (e.g., newly diagnosed, younger women, recurrence, active treatment) _____
 - Educational Programs, Seminars/Topic of Interest: _____
 - Referral to Resources/List Type: _____

ADDITIONAL INFORMATION

- I WOULD LIKE TO RECEIVE YOUR NEWSLETTER AND UPDATES ON EVENTS
- I WOULD LIKE TO PARTICIPATE IN THE ANNUAL GOLF OUTING EVENT
- I AM INTERESTED IN JOINING ONE OF YOUR COMMITTEES
- I AM INTERESTED IN JOINING YOUR BOARD OF DIRECTORS
- I WOULD LIKE TO MAKE A DONATION

HOW DID YOU HEAR ABOUT JD BREAST CANCER FOUNDATION: _____

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MEDICAL INFORMATION (To be completed ONLY by Oncology Physician's Office-May be completed by Doctor, Nurse or Licensed Social Worker)

Primary Cancer: _____ Stage of Cancer: _____

New Diagnosis Date of Initial Diagnosis: _____ Stage: _____

Recurrence Date of Recurrence: _____ Stage: _____

Are you in active treatment? Yes No

If yes, please indicate type & frequency of treatment (please check all that apply):

Chemotherapy Radiation Surgery

Frequency of treatment (explain): _____

Clinical Trial Hormonal Complementary/Alternative

Frequency of treatment (explain): _____

Physician's Name: _____ Hospital/Clinic: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Print Name/Title of person completing this form: _____

Signature of person completing this form: _____

Phone (if different from above): _____ Email: _____

Doctor, Nurse or Social Worker Recommendation for Assistance: _____

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BIOGRAPHY/NEEDS ASSESSMENT (*Explain how having breast cancer has created a financial hardship for you*):

The JD Breast Cancer Foundation provides critical and urgent financial assistance to women of all ages who are in active treatment for breast cancer and trying to survive on little or no income, or without health insurance.

While undergoing breast cancer treatment coupled with the physical challenges after treatment, women face unpredictable hardships. These hardships include overwhelming medical expenses, loss of income, loss of a marriage, loss of child care and much more. This section provides an opportunity to share your story, specifically how breast cancer has impacted you financially. Please use the space below and no more than one additional sheet of paper (if needed) to indicate your specific circumstances (duration of your cancer, what immediate needs you have, special work/income limitations, etc.). If the Financial Information indicates that your current income exceeds your expenses, please explain the circumstances.

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AGREEMENT AND SIGNATURE

Please read and sign below after you have carefully reviewed your completed application.

I hereby authorize the JD Breast Cancer Foundation to release my personal & medical information with other organizations JD Breast Cancer Foundation might collaborate with in order to provide me with financial assistance.

I understand that assistance approvals may sometimes result in general publicity. However, my name will never accompany such release.

I understand that there is a limit to the number of services that I may receive within a 12 month period and that there is no promises or guarantees that financial assistance will be provided.

By signing this application, I confirm that I am solely responsible for the accuracy of all information contained herein and agree with the contents of this agreement as stated above.

Applicant's Signature

MEDICAL RECORD RELEASE & AUTHORIZATION

Ohio and Federal law protect the privacy and confidentiality of an individual patient's medical records. In order for The JD Breast Cancer Foundation to access your medical records (as part of its financial assistance process), a Release and Authorization form must be executed and submitted to your health care provider(s). Please note that you are afforded the following rights with respect to the Release and Authorization:

You may refuse to sign the Release and Authorization form (you will be ineligible to receive financial assistance).

You may revoke the Release and Authorization by submitting a written revocation to the health care provider.

The revocation will be effective upon receipt by the healthcare provider.

You have the right to receive a copy of this Release and Authorization upon written request.

You may inspect or obtain copies of all information which the Foundation receives pursuant to this Release and Authorization.

I hereby authorize my health care provider to release any health care and billing information regarding my breast cancer treatment, diagnosis, prognosis, etc. to the JD Breast Cancer Foundation. The purpose of this request is to assist the JD Breast Cancer Foundation in determining my eligibility for financial assistance.

This Release and Authorization shall expire twelve (12) months from its execution, if not revoked prior thereto.

Applicant's Signature

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Please Use This Checklist to ensure proper completion of the application

Application

- ___ Personal Information
- ___ Employment Information
- ___ Financial Information
- ___ Insurance/Prescription Information
- ___ Assistance Request Section ***(included all required documentation - ie., mortgage statement, rental agreement, statement from landlord)***
- ___ Insurance/Prescription Information Assistance Request
- ___ Additional Information
- ___ Medical Information Section ***(completed by Oncology Physician's Office only)***
- ___ Biography/Needs Assessment Section ***(Clear explanation of how having breast cancer has created a financial hardship)***
- ___ Agreement & Signature (Signed both sections)
- ___ Medical Record Release & Authorization

Supporting documentation (Must be the most recent, show account information, Company Name, Mailing Address and phone number)

- ___ Utility bills
- ___ Mortgage statement
- ___ Rental agreement
- ___ Transportation
- ___ Prescription/Invoice

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