CONFIDENTIAL APPLICATION FOR FINANCIAL ASSISTANCE
www.jdbcfoundation.org
216-791-9447

Applicant Name: _____

The JD Breast Cancer Foundation is a non-profit 501(c)(3) tax-exempt organization that is committed to helping women and families affected by breast cancer. Project Lifeline provides critical and emergency financial assistance to women who are currently in active treatment for breast cancer.

GUIDELINES

- An applicant must be in active treatment or completed active treatment within the last 12 months.
- An individual may submit an application once every 12 months.
- An applicant must reside in Northeast Ohio (22 counties in the Northeast Ohio Komen Affiliate) to be eligible for assistance.
- Assistance is determined by applicant's needs and the availability of funding.
- The type and amount of assistance will be determined on a case-by-case basis by the JD Breast Cancer Foundation Program Advisory Committee.
- Application submission does not assure assistance will be granted.
- Approved applicants will receive a one-time aid disbursement and will not be guaranteed future financial assistance from this organization.
- Applicants will receive a response by mail within 30 days upon receipt of the completed application with all supported financial documents.
- All applications will be evaluated on a non-discriminatory basis with no regard to age, race, ethnicity, or creed.
- Payment will be paid directly to the service provider (*i.e.*, utility company, landlord), not applicant.

INSTRUCTIONS

- Answer each question completely. If an item does not apply to your situation, please mark with "N/A."
- Sign and date the application.
- Have your **Oncology physician's office** complete the Medical Information section. The physician, nurse, or social worker may complete this section.
- If requesting housing assistance, applicant must submit a copy of the mortgage statement or rental agreement.
- Submit copies of any applicable utility bills. All documents submitted must be **the most recent (within 30 days)**, include the account information, Company Name, Mailing Address and phone number.
- Provide the best contact information where you can be reached to answer any additional questions.

Please Note: Proper Documentation is required to complete the application process. Incomplete applications will delay processing.

Please return this application to:

JD Breast Cancer Foundation
Attn: Program Advisory Committee
14837 Detroit Avenue, #295, Cleveland, OH 44107
Fax: 216-916-4466
Email: pink@jdbcfoundation.org

Applicant Name: _____

PERSONAL INFORMATION			
Date: / /			
Applicant's Full Name:			
Address:		**Age:**	**Date of Birth:**
City:	**County:**		
State:	**Zip:**		
Primary Phone Number: ( )	**Alternate Phone Number:** ( )		
Email:			
Race/Ethnicity (*for data collection purposes only*):			
Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Separated** ☐ **Divorced**			
Spouse's Full Name: *(If legally married, spouse's 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 and ages of adults/children living in household:			
Name:	**Age**:	**Name**:	**Age**:
Name:	**Age**:	**Name**:	**Age**:
Name:	**Age**:	**Name**:	**Age**:
Do you own or rent this home? ☐ **Rent** ☐ **Own** ☐ **Other**			
If you rent, please list your landlord's name, address to which rent payments are sent, and contact number below:			
Name:			
Address:			
Contact Number:			

Applicant Name: _____

Have you previously received assistance from our Foundation? ☐ **Yes** ☐ **No**	
If yes, please provide the following information:	
Date: / /	
Assistance Provided:	
Have you previously applied for financial assistance from our Foundation and been denied? ☐ **Yes** ☐ **No**	
Have you previously applied to or received assistance from another cancer foundation? ☐ **Yes** ☐ **No**	
If yes, please provide the following information:	
Date: / /	**Date: / /**
Foundation Name:	**Foundation Name:**
Assistance Provided:	**Assistance Provided:**
How did you hear about our organization:	
If you were referred by someone, please list their name:	
Please list any additional organizations that you are aware of that would be beneficial to others who are battling breast cancer:	
Organization Name:	**Organization Name**:
Organization Name:	**Organization Name**:
What other JDBCF cancer services are you interested in?	
_____ I would like to receive updates on events (including community health fairs and fundraisers	
_____ I am interested in volunteering or joining one of your committees	
_____ I am interested in financial counseling services through a local bank	

Applicant Name: _____

EMPLOYMENT INFORMATION *(You must provide employment information for all individuals in the same household as applicant)*	
Applicant's Employer and Occupation:	
Employer's Address:	
Current Employment Status *(full-time, part-time, unemployed, FMLA, retired, disability, etc.)*:	
Monthly Income **Before Taxes** While Employed: $	
Hire Date: / /	Date Last Worked: / /
If you are on leave (FMLA, short-term disability), please provide the following information:	
Last Paycheck Date: / /	Expected Return Date: / /
If unemployed, retired, or disabled please list most recent two employers, dates of employment, and reason for leaving: *(i.e. laid off in 2015 or unable to work because)*	
Do you have any other sources of income? ☐ Yes ☐ No	
If yes, please describe source and monthly income: *(i.e. wages from second job, pension, social security, disability, alimony, etc.)*	
How has breast cancer affected your employment status?	
Spouse's Employer and Occupation *(if applicable)*:	
Employer Address:	
Current Employment Status *(full-time, part-time, unemployed, FMLA, retired, disability, etc.)*:	
Monthly Income **Before Taxes** *(include wages, pension, social security, disability, alimony, etc)*: $	
Other Adult Person Living in Household's Employer and Occupation *(if applicable)*:	
Relationship to Applicant:	
Employer Address:	
Current Employment Status *(full-time, part-time, unemployed, FMLA, retired, disability, etc.)*:	
Monthly Income **Before Taxes** *(include wages, pension, social security, disability, alimony, etc)*: $	

Applicant Name: _____

FINANCIAL INFORMATION	
Total Monthly Income from <u>All Persons</u> Living in Household:	
Total Wages for All Adults Before Taxes:	$
Total Take Home Pay for All Adults *(amount in your check after taxes):*	$
Total Pension Income for All Adults:	$
Total SSI Income for All Persons:	$
Total SSD Income for All Persons:	$
Total Alimony Income for All Persons:	$
Total Child Support Income for All Persons:	$
OVERALL INCOME:	**$**
Total Amount Received from Welfare/Food Stamps:	$
Total Liquid Assets *(cash, checking or savings balances, money market accounts, CD's, stocks)*:	$
Monthly Expenses:	
Gas:	$
Electricity:	$
Water:	$
Sewer:	$
Home/Primary Phone *(just phone, not internet)*:	$
Transportation *(car, insurance, and public transportation costs)*:	$
Average Medical Expenses:	$
Health Insurance:	$
Rent/Mortgage:	$
Property Taxes, & Mortgage/Home Owners Insurance:	$
Food:	$
Child Care:	$
Clothing and Household Expenses:	$
Other Loans *(student loans, home equity, lines of credit)*:	$
TOTAL EXPENSES:	**$**

Applicant Name: _____

INSURANCE AND PRESCRIPTION INFORMATION	
Type of Health Insurance *(please check all that apply)*:	
☐ Private Health Insurance Provider *(i.e. Medical Mutual, Kaiser, etc.)*	☐ Medicare
☐ Medicaid	☐ Medicare Plus Medicaid
☐ Medicaid Pending	☐ Medicare Plus Other Supplemental Coverage
☐ Other:	☐ Disability
☐ None	
Are Prescription Drugs Covered? ☐ Yes ☐ No	**Name of Primary Insurance:**
Are Co-Pays Covered? ☐ Yes ☐ No	**If Not, State Out-of-Pocket Expense:**

ASSISTANCE REQUEST		
For what purpose are you seeking financial assistance?		
☐ Housing Costs	☐ Transportation	☐ Food Costs
☐ Utility Costs	☐ Home Care	☐ Post-Surgical Products *(prosthesis, bras, gauntlets)*
☐ Other:		

Documents Submitted: *(must be in applicant's name or in the name of an adult living in the residence):*	
☐ Gas Bill	☐ Electric Bill
☐ Phone Bill	☐ Mortgage/Rent Statement
☐ Invoice for Post-Surgical Products	☐ Transportation Costs
☐ Invoice for Prescription Costs & Copy of Written Prescription	☐ Other:
Total Amount That You Are Requesting in Assistance:	**$**

Applicant Name: _____

MEDICAL INFORMATION *(To be completed ONLY by Oncology Physician's Office by Doctor, Nurse, or Licensed Social Worker)*		
Primary Cancer:	**Stage of Cancer**:	
☐ New Diagnosis	Date of Initial Diagnosis: / /	Stage:
☐ Recurrence	Date of Initial Diagnosis: / /	Stage:
Is the Patient in Active Treatment? ☐ Yes ☐ No		
If yes, please indicate type and frequency of treatment *(please check all that apply)*:		
☐ Chemotherapy – start date and frequency: / /		
☐ Radiation – start date and frequency: / /		
☐ Surgery – date/estimated date:		
Explain prescribed plan for next 3 months:		
Physician's Name:	**Hospital/Clinic:**	
Address:		
City/State/Zip:	**Phone Number:** ( )	**Fax Number:** ( )
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:		

Applicant Name: _____

BIOGRAPHY/NEEDS ASSESSMENT
This section provides you with an opportunity to share your story; more specifically how breast cancer has created a **financial hardship** for you. Please be as specific and concise as possible. Be sure to include your specific circumstances such as the duration of cancer, what immediate needs you have, special work/income limitations, etc. If your current income exceeds your expenses, please explain the circumstances as to why you are in need of assistance.

Applicant Name: _____

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 and 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 I may receive within a 12-month period and that there is no promise or guarantee 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:	**Date:** / /

MEDICAL RECORD RELEASE AND 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 (12) months from its execution, if not revoked prior thereto.

Applicant's Signature:	**Date:** / /

Applicant Name: _____

CHECKLIST *(Please use this checklist to ensure proper completion of the application)*
Application
_____ Personal Information
_____ Employment Information
_____ Financial Information
_____ Assistance Request Section *(include all required documentation – i.e. mortgage statement, rental agreement, etc.)*
_____ Insurance/Prescription Information
_____ Additional Information
_____ Medical Information Section *(completed by Oncology Physician's office ONLY)*
_____ Biography/Needs Assessment Section *(clear and concise explanation of how having breast cancer has created a financial hardship)*
_____ Agreement and Signature
_____ Medical Record Release and Authorization
SUPPORTING DOCUMENTATION *(Must be the most recent copy of a full utility bill (not just the payment coupon), show account number, account holder's name, company name, payment mailing address, and phone number.)*
_____ Utility Bills
_____ Mortgage Statement
_____ Rental Agreement *(include landlord's name, address, and contact information)*