# *Cynthia's Breast Cancer Giving Circle, Inc.*

# *Financial Assistance Program 2019 Application Southeastern Wisconsin*

**Cynthia's Brief Testimony:**
"As a result of going through the breast cancer experience twice (April 2007 and October 2009), I recognized a lack of financial resources in time of need. Striving to keep my focus on healing and coping with the financial struggle was beyond words. Therefore, from my experience, I desire to help others in similar situations who have a financial need."

Cynthia's Breast Cancer Giving Circle, Inc. (CBCGC) mission is to provide hope by relieving the mental stress and financial hardship to breast cancer or other cancer patients/survivors who are going through medical treatment.

Our unique "Giving Circle" consist of heartfelt individuals who pool their funds together to donate toward a worthy cause for those impacted by cancer in our communities.

The central focus is to assist cancer patients/survivors with basic living and medical expenses, such as:

- Rent or Mortgage
- Utilities
- Telephone Service
- Medical Expenses

<u>In order to be considered for our financial assistance program (June 1 – November 15)</u>:

1. Must be in active medical treatment for breast cancer or other cancer types.
2. Complete the entire application and provide copies of <u>all</u> required documents.
3. Provide the completed Medical Record Release and Authorization to your medical provider.
4. Have the Physician's Statement completed by your doctor.

**The application with attachments should be submitted and post-marked by November 15, 2019**. If you have any questions, please call CBCGC at (414) 828-8689 or Email us at: cbcgcinc@gmail.com for more details.

**All applicants will be notified by mail within 3-4 weeks.** If approved, distribution for payment will be made payable to the creditor (f/b/o recipient).

## Who is eligible?

- Women and Men 18 years or older
- Cancer patients actively undergoing medical treatment that have a financial need
  - Uninsured, Underinsured, or Individuals that have a Current Need
- Central focus: Residents of Southeastern Wisconsin (Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, and Waukesha Counties) and our vision is to assist all areas of Wisconsin.

**A complete review of <u>all</u> documents submitted will assist the Review Committee with determining grant approval and amounts (Minimum $500).**

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| Resources | |
|---|---|
| American Cancer Society<br>800-227-2345<br>www.cancer.org | CancerCare<br>800-813-4673<br>www.cancercare.org |
| Cancer Financial Assistance Coalition<br>www.cancerfac.org | Cancer Hope Network<br>800-552-4366<br>www.cancerhopenetwork.org |
| Coping with Cancer Magazine<br>Subscribe by phone: 615-791-3859<br>www.copingmag.com | Help Now Fund<br>Email: info@igopink.org<br>www.thebreastcancercharities.org |
| Milwaukee Regional Cancer Care Network<br>www.wisecancercarenetwork.org | The Pink Fund<br>888-477-2669<br>www.thepinkfund.org |
| UniteMKE<br>The Bridge to Community Health<br>www.unitemke.org | SHARE<br>844-275-7427 (Helpline)<br>www.sharecancersupport.org |

Revised: 05/13/2019

**Return Application to:**
CBCGC, Inc.
Attn: Review Committee
PO Box 76083
Milwaukee, WI 53216

**For more information call:** (414) 828-8689
Email: cbcgcinc@gmail.com
Website: www.cbcgc.org

CBCGC, Inc. is a 501(c)(3) Non-profit Organization (public charity)

*Cynthia's Breast Cancer Giving Circle, Inc.*

## Financial Assistance
## 2019 Grant Fund Application
**CONFIDENTIAL**

### PATIENT INFORMATION
(PLEASE PRINT)

First Name:_____Last Name:_____Date of Birth:_____

Address:_____ City, State, Zip:_____

Phone Number/Home:(  ) _____ Work:(  ) _____

Cell Number:(  ) _____ Email Address:_____

☐ Female/ ☐ Male - Ethnicity: ☐ African American/ ☐ Asian American/☐ Caucasian American/☐ Hispanic & Latino American / ☐ Native American/☐ Other _____

How many times have you applied for financial assistance with our program (circle)? 1st 2nd 3rd

Referral – how did you hear about us? _____

### MEDICAL INFORMATION

Date of Diagnosis: _____Primary Cancer Type: _____ Stage: _____

☐ New Diagnosis ☐ Recurrence Are you in active treatment? ☐ Yes No – does not meet criteria

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

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Other _____

### HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No

If yes, please indicate type of insurance (check all that apply):

☐ Private Health Insurance ☐ Medicaid ☐ Medicare ☐ Medicare plus Medigap ☐ Charity Care ☐ VA Program

☐ Other _____

Are prescription drugs covered? ☐ Yes ☐ No

(***Personal information will not be shared with any other business or entity***)

## HOUSEHOLD FINANCIAL INFORMATION

Are you currently employed? ☐ Yes ☐ No Number of people in household: _____

**REQUIRED: PLEASE PROVIDE A COPY OF YOUR CURRENT MONTHLY INCOME**

**Current**: Monthly income: _____ Monthly expenses: _____

**Family Income Sources** (please check all that apply):

☐ Salary ☐ Social Security (Retirement) ☐ Pension ☐ Unemployment

☐ Public Assistance ☐ SSD (Disability) ☐ SSI (Income) ☐ Family/Friends provide support

Are you receiving short or long term disability benefits? Short: ☐ Yes ☐ No / Long: ☐ Yes ☐ No
If yes, ☐ Employer or ☐ Private

Below is a list of basic living and medical expenses which are covered under the financial assistance grant fund. Based on your needs, please indicate under each service type the amount you're requesting along with providing a **copy** of the current document(s) required for payment. If needed, further verification may be required.

| SELECT SERVICE<br>✓ THE BOX | | DOCUMENTATION REQUIRED FOR PAYMENT | AMOUNT |
|---|---|---|---|
| | Rent or Mortgage | Copy of Lease Agreement or<br>Copy of Monthly Statement | $ |
| | Utilities<br>- Electric/Gas<br>- Water | Copy of Monthly Statement | $<br>$ |
| | Telephone Service<br>- Land line/Cell | Copy of Monthly Statement | $ |
| | Medical Expenses<br>- Hospital/Treatment<br>- Prescriptions<br>Only for treatment related service | Copy of Medical Statement | $<br>$ |

By signing this application, I state that the information provided is true and complete. I understand that any false information or omissions will disqualify me from receiving assistance (i.e., grant award). Further, I understand and agree that no promises or assurances have been made to me by any representative of CBCGC regarding the assistance I am requesting.

_____ _____

Signature of Applicant Date

## PERSONAL STATEMENT

Please use the space below to tell us "your story" so that we might get acquainted and better understand your need for our assistance.

## PUBLICITY RELEASE

Are you willing to share your experience with CBCGC? Sharing may include a print or TV story.

□ Yes, you have permission to use my (if photo is selected send with application or by email):
□ Photo □ Story □ First Name □ First and Last Name

Signature of Applicant Date

□ No, I prefer that CBCGC not use my personal information in their publicity efforts and wish to remain anonymous. I understand this will not in any way exclude me from receiving assistance.

## MEDICAL RECORD RELEASE AND AUTHORIZATION

Federal law protects the privacy and confidentiality of an individual patient's medical records. In order for Cynthia's Breast Cancer Giving Circle, Inc. (herein called "CBCGC") to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be signed 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; however, you will then be ineligible to receive financial assistance from this fund.
- You may revoke the Release and Authorization Form by submitting a written revocation to the health care provider.
- The revocation will be effective upon receipt by the health care provider.
- You may inspect or obtain copies of all information which CBCGC receives pursuant to this Release and Authorization.

I hereby authorize the release of my medical information to CBCGC and specifically authorize for a Physician's Statement to be obtained in regard to my cancer treatment only.

| | |
|---|---|
| Applicant Signature | Home Address |
| Date Signed | City, State, Zip |
| Applicant Name (Please print) | Date of Birth / Home Phone No. |

| Physician Name (Please Print) | Physician Name (Please Print) |
|---|---|
| Address | Address |
| Phone No. (include area code) | Phone No. (include area code) |

***Provide original copy to the health care facility, retain one (1) copy for your records, and submit one (1) copy to CBCGC.***

# PHYSICIAN'S STATEMENT

**Please Return Completed Form To:**
CBCGC, Inc., Attn: Review Committee
PO Box 76083 – Milwaukee, WI 53216
Or by Email: cbcgcinc@gmail.com

Applicant Name (Please Print)

_____

Date of Birth (MM/DD/YY) / Phone Number

The purpose of this form is to help us confirm your patient, our applicant, is currently undergoing medical treatment and to determine his/her eligibility for financial assistance with Cynthia's Breast Cancer Giving Circle, Inc. In order to accurately assess his/her application, please complete all entries listed below and return to the address above as soon as possible.

1. What is the medical diagnosis you are treating this patient for? _____

_____

_____

2. Date of Diagnosis: _____ Stage: _____

3. What type of treatment is being provided? _____

_____

_____

4. Date of most recent treatment: _____ Number of treatments: _____

5. Has the patient experienced any side effects to the treatment? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____ _____ _____

Physicians Signature License No. Date

_____ _____ _____

Specialty Phone No. Fax No.

_____ _____

Street Address City, State, Zip