

**BREAST CANCER FOUNDATION OF THE OZARKS  
APPLICATION FOR LYMPHEDEMA PROGRAM**

If approved, all payments for garments will be made directly to the medical provider or medical supply company.

Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SS#: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ - \_\_\_\_\_  
 Telephone No.: \_\_\_\_\_ Email: \_\_\_\_\_ County: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Children: \_\_\_\_\_ Other Dependents: \_\_\_\_\_  
 Medical Diagnosis: \_\_\_\_\_  
 Physician: \_\_\_\_\_

What type of garment do you need? \_\_\_\_\_

Other Agencies you are currently working with: \_\_\_\_\_

**Health Coverage:** \_\_\_No \_\_\_Yes If yes, Circle TYPE: Personal Policy, Through Employer, Medicare, Medicaid  
**Does your coverage include lymphedema garments?** \_\_\_\_\_

**Amount Requested For Garment if known:** \_\_\_\_\_

**FINANCIAL INFORMATION:**

	<u>Monthly Income</u>	<u>Monthly Expenses</u>
Employment: Patient:	\$ _____	Rent/Mortgage: \$ _____
Spouse:	\$ _____	Utilities: \$ _____
Other:	\$ _____	Food: \$ _____
Retirement: Social Security:	\$ _____	Insurance Health: \$ _____
VA Pension:	\$ _____	Insurance Home: \$ _____
Employee Pension:	\$ _____	Insurance Car: \$ _____
Other Income: Alimony:	\$ _____	Medical: \$ _____
Child Support:	\$ _____	Car Payment: \$ _____
Investments:	\$ _____	Credit Card Debt: \$ _____
Public Assistance:	\$ _____	Other Expenses: _____
Workmen's Comp:	\$ _____	_____
Unemployment:	\$ _____	_____
Disability:	\$ _____	_____
Insurance:	\$ _____	_____
Savings:	\$ _____	_____

Assets: (If more space needed, please attach separate sheet)	Value
_____	_____
_____	_____
_____	_____

Enclosed is a release form with information for you to send to or give your health care provider so our organization can make contact for verification of your breast cancer status if needed. This release is in accordance with HIPPA guidelines.

I hereby certify that I have developed lymphedema as a result of surgery or treatment related to breast cancer. I also certify that the above information is true and correct. All information is considered confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient/Family Member/Other

**PLEASE RETURN TO:** 330 North Jefferson, Suite B, Springfield, Missouri 65806  
**OR CALL:** 417-862-3838 or 1-866-874-1915 for answers to questions in reference to this form.

