

BREAST CANCER FOUNDATION OF THE OZARKS
APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or on going consequences of treatment related to breast cancer. Application for assistance will be individually evaluated by our organization after completion of this form and verification from your health care provider concerning your breast cancer status. Please fill this form out completely.

Name: _____ D.O.B: _____ SS#: _____
 Address: _____ City: _____ Zip: _____ - _____
 Telephone No.: _____ Email: _____ County: _____
 Spouse: _____ Children at home and ages: _____ Other Dependents: _____
 Medical Diagnosis: _____
 Physician: _____

Please state the intended use for the funds requested: _____

Other Agencies you are currently working with: _____

Employer (if applicable) _____

Health Coverage: ___No ___Yes If yes, Circle TYPE: Personal Policy, Through Employer, Medicare, Medicaid

BCFO pays to invoice only, cash is not provided.

Amount Requested: _____ { BCFO does not pay Medical ,Phone,or Pharmacy bills. }

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:	\$ _____	Auto 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 medical records release form you will need to fill out so that BCFO can receive information verifying your breast cancer status. I hereby certify that I have been diagnosed with breast cancer and require financial assistance. 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, Springfield, MO 65806
OR CALL: 417-862-3838 for help with questions

