It's a Breast Thing Patient Assistance Program

Application for Assistance

This form is confidential – please type or print – If we cannot read your application you will not be considered.

Please Answer All Questions

Where did you hear about us? _____

Patient Information

First Name: _____ Last Name: _____

Address: (include street address if mailing address is a P.O. Box)

_____

City: _____State: _____ Zip: _____ County: _____

Home Phone: _____ Cell Phone: _____

County in which you are receiving your treatment _____

Email Address: (required) _____

Please answer the questions below, use additional paper if needed.

What is your monthly household income? Include all sources - wages, state or federal aid money, interest, dividends, spouse's income, etc.

_____

Please list your current monthly bills and payments including all debts – mortgage, rent, car, utilities, credit card, etc. Use a separate sheet of paper, if necessary.

_____

Do you have medical insurance?

_____

Have you received financial support from another organization? If yes, list which organization(s) and the amount.

_____

How will you use any financial assistance received from It's a Breast Thing?

_____

Physician and Treatment Information

Please list the name(s) and address(es) of the doctor(s) who are treating you for breast cancer.

What is the name of the cancer center or hospital where you are being treated? Please list the name of a contact person such as a nurse or social worker at your doctor's office in case we have to ask a question.

Do you attend a breast cancer support group? If so, please list the name of the group(s).

How did you hear about It's a Breast Thing?

Patient Release of Information

I _____, (your name) have contacted the It's a Breast Thing Assistance Program for assistance and hereby authorize my doctor to release information regarding my illness and its treatment to the It's a Breast Thing Assistance Program Administrator(s). I am submitting this application for assistance due to the financial burden incurred as a result of my diagnosis of breast cancer.
All information included in this application is accurate to the best of my knowledge.

Applicant's Printed Name: _____

Applicant's Signature: _____ Date: _____

Mail this completed application and all the supporting documents listed in the instructions to: It's a Breast Thing Assistance Program, P.O. 743, East Lansing, MI 48826