

## IT'S A BREAST THING APPLICATION FOR ASSISTANCE



It's a Breast Thing will serve patients that reside and are receiving treatment in the Mid-Michigan area. Which means, if the patient **lives within the designated Mid-Michigan area AND is receiving treatment within the same Mid-Michigan area**, then the patients will be eligible for an IBT Grant. The patient must also complete the grant application requirements.

All patient information is confidential. Application must be clearly legible to be considered for the grant. Please print or fill out the form using Acrobat Reader and select the Submit button below to email a copy of the form.

Have you ever received a grant from It's a Breast Thing (IBT)? Yes                      No

If YES, when and for what amount?

**Patient Information:** (please be sure all information is clear and legible)

**First name:**

**Last name:**

**Address of current residence:**

**PO Box (if different from street address)**

**City:**

**State:** Michigan **Zip:**

**County in which the patient resides:** (Check one)

Eaton	Saginaw	Washtenaw	Bay
Ingham	Ionia	Livingston	Isabella
Clinton	Kent	Genesee	Mecosta
Shiawassee	Barry	Montcalm	Midland
Gratiot	Calhoun	Jackson	

**Phone number:**

**Email:**

**County in which patient is receiving treatment:** (Check one)

Eaton	Saginaw	Washtenaw	Bay
Ingham	Ionia	Livingston	Isabella
Clinton	Kent	Genesee	Mecosta
Shiawassee	Barry	Montcalm	Midland
Gratiot	Calhoun	Jackson	

**How many people live in the above residence?**

**Please include yourself, partner, spouse, and all eligible dependents.**

**What range is your annual income?** Please include all sources, wages, state or federal aide, interest, dividends, as well as that of other wage earners in the household.

Less than \$17,000

\$17,000-\$30,000

\$31,000-\$45,000

\$46,000-\$60,000

\$61,000 +

**Are you currently receiving Social Security Benefits?**      Yes      No

**If Yes, please indicate which type.**

SSI (Social Security Income)

SSD (Social Security Disability)

**Please check any of the following programs you are currently involved with:**

503 Individual (Pickle)

QMB, SLMB, ALMB, QDWI – Medicare Savings Program

COBRA Widowers

AD Care – Aged and Disabled

Early Widowers

Extended Care

DAC – Disabled Adult Children

Freedom Work

SDC – Special Disabled Children  
(4913 Zebley)

**Have you received financial support from any other organization?**    Yes            No

**If Yes, please name the organization.**

**Physicians and Treatment Information**

Please list the names of the physicians and the office addresses of those that are treating you for breast cancer.

**Physician #1**

**Name:**

**Contact Person:**

**Address:**

**City:**

**Michigan    Zip:**

**Physician #2**

**Name:**

**Contact Person:**

**Address:**

**City:**

**Michigan    Zip:**

**Physician #3**

**Name:**

**Contact Person:**

**Address:**

**City:**

**Michigan Zip:**

**Do you attend a breast cancer support group?**    Yes                  No

**If Yes, what is the name of the group and where do they meet?**

**How did you find out about the IBT Grant?**

From a Physician

Referred by caregiver

Friend or family member

IBT event

IBT website or other website    Other:

**Patient Information Release Authorization**

I, \_\_\_\_\_ (enter patient full name) have contacted It's a Breast Thing Assistance Program for financial support and hereby authorize my doctor, (Enter physician's name) to release information regarding my illness and treatment to the It's a Breast Thing administrator. I am submitting this application due to the financial burden incurred because of my breast cancer diagnosis. All information included in this application is accurate and complete to the best of my knowledge.

**Applicant/patient name:**

**Applicant/patient signature:**

Mail or Email completed application and all supporting documents listed in the instructions to:

It's a Breast Thing – Non-Profit Assistance Program

PO Box 743

East Lansing, MI 48826