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

Have you ever received a grant from It's a Breast Thing and if so how many? _____

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.

How many are in your household? Only include yourself/partner and all eligible dependents.

_____

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

_____

Are you currently receiving Social Security Benefits?

- ☐ Yes
- ☐ No

If yes, which type?

- ☐ SSI (Social Security Income)
- ☐ SSD (Social Security Disability)

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Are you currently in any of the following programs:

- ☐ 503 Individuals (Pickle)
- ☐ COBRA Widowers
- ☐ Early Widowers
- ☐ Disabled Adult Children (DAC)
- ☐ Special Disabled Children (SDC)
- ☐ 4913 – Zebley Medicare Savings Program (QMB, SLMB, ALMB, QDWI)
- ☐ Aged and Disabled (AD Care)
- ☐ Extended Care
- ☐ Freedom to Work

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) addresses (s) 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 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).

_____

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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: _____

You must include the following items with your application:

1. Proof of U.S. Citizenship or legal residency. Copy of Birth Certificate, Passport or documentation showing current and valid legal residency.
2. Copy of Drivers License or State Identification card showing your current address.
3. A copy of page 1 of your current income tax return showing proof of income.
    a. If you are not working you must show proof of household income.
    b. If you are only receiving social security payments, you must attach proof of amount.
    c. If you are only receiving unemployment or medical disability, you must attach proof of amount.
4. A letter on your physician's letterhead, signed by your physician stating you are currently in treatment for breast cancer. Must be an original copy.

Mail this 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