Our mission:
To inspire hope and enhance life for those affected by breast cancer
through early detection, advocacy, education and support services

BREAST CANCER ASSISTANCE APPLICATION

APPLICANT INFORMATION

Name:		
Date of birth:	Email:	Phone:
Current address:		
City:	State:	ZIP Code:
Diagnosis and Date of Onset:		
Tell us where you are in your treatment- past/present and anticipated date of completion: (if you have had surgery please indicate lumpectomy or mastectomy).		
Physician:		Phone:
Referral source		
Contact email/phone for the person who referred you to program:		
How did you hear about this program? (internet, krewe website, rack card, physician, friend, other)		

SIGNATURE

Signature of applicant:	Date:

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HOUSEHOLD INFORMATION

Marital Status:

Please list all members of your household and indicate those who are dependent upon your support:

INSURANCE INFORMATION

Insurance carrier and monthly premium:

Deductible and MAXIMUM out of pocket:

Co-pays and or co-insurance:

Does the applicant or anyone in the household receive Medicare or Medicaid? If you do not have insurance have you applied for Medicaid?

EXPENSES AND INCOME

Please list ALL MONTHLY household expenses:

Housing/Food:

Utilities (to include power, water, garbage):

Car payments:

Other expenses not listed here:

TOTAL monthly household expenses:

INCOME: This includes ALL contributing members of the household (spouse, partners etc count!!)

Employer and Salary:

Social Security (S.S.I.)/Social Security Disability (S.S.D.I.)

Alimony or child support**

Veteran's Benefits:

Unemployment (if applicable):

Other sources of income not listed:

TOTAL amount of monthly income: (This includes all sources)

****The Breast Cancer Assistance Program is a program of last resort. Please tell us about any other agencies that you have received assistance from or have been denied/turned away for lack of funding:

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PROPOSED USE OF FUNDING	
Please be specific: We are only able to provide funding for documented expenses and require receipts/EOB's /bills for our records.	
Appointments/treatments :	
Tests/procedures:	
Medications:	
Bras/wigs/turbans:	
Housecleaning:	
Transportation to and from appointments/treatments:(if submitting for fuel reimbursement you must include receipts!)	
Family crisis intervention:	
Any other expenses not listed above:	
Total Amount Requested:	
SIGNATURES	
Signature of applicant:	Date:

*** Please note- By signing this form, the applicant gives The Keeping Abreast Foundation Breast Cancer Assistance Program permission to contact the above physician to verify diagnosis, medical necessity and current/outstanding medical bills as governed by HIPAA law.

Requests for funding are not guaranteed and will be reviewed and met as funds are available and approved.

The Keeping Abreast Foundation Breast Cancer Assistance Program

HIPAA Privacy Authorization Form

** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164) **

Authorization

I authorize _____(healthcare provider)
to use and disclose the protected health information described below to The Keeping Abreast Foundation Breast Cancer Assistance Program.

Effective Period
This authorization for release of information covers the period of healthcare
from:

_____ to _____.
OR

□ all past, present, and future periods.

Extent of Authorization

□ I authorize the verification of medical diagnosis
AND/OR
□ verification of current/outstanding medical bills

□ other

This medical information may be used by the person I authorize to receive
this information for verification of medical diagnosis, current and outstanding medical bills or other purposes as I may direct.

This authorization shall be in force and effect until

_____ (date or event), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing,
at any time. I understand that a revocation is not effective to the extent that any
person or entity has already acted in reliance on my authorization or if my
authorization was obtained as a condition of verification of my medical diagnosis and/or medical bills.

I understand that information used or disclosed pursuant to this
authorization may be disclosed by the recipient and may no longer be protected by
federal or state law.

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative and his or her relationship to patient

Date:

Please email or mail completed form to:
The Keeping Abreast Foundation Breast Cancer Assistance Program
Po Box 10812
Pensacola, Florida 32504
thekabfoundation@gmail.com