TOUGH ENOUGH TO WEAR PINK OF MONTANA

CONFIDENTIAL APPLICATION
FOR FINANCIAL ASSISTANCE

At this time, Tough Enough to Wear Pink of Montana makes grants to individuals residing in Montana

- Tough Enough To Wear Pink of Montana is a non-profit 501(c)(3) tax-exempt organization that provides assistance to individuals with breast cancer.
- You will be notified by mail within approximately 90 days as to whether or not your application has been approved.
- All applicants may re-apply after 1 year.
- Funds are limited; grants are based upon availability funds and the applicant's need, and are in no way based upon race, creed, national origin, or ethnicity.
- Assistance may be in the form of a monetary payment to the applicant, a payment directly to a creditor, a gift certificate for staple items, or the like. Forms of assistance will be decided on a case by case basis by the Board of Directors of TETWP of Montana.
- Approval of a request represents a one-time assistance payment and does not in any way constitute a promise of future financial assistance.
- All information is held in the strictest confidence and is used only by TETWP of Montana for the purpose of reviewing financial assistance needs. The information required in this application is necessary for us to determine whether granting assistance to you is consistent with our organization's charitable purposes for which we have been granted tax exempt status by the IRS and the State of Montana.

PLEASE BE SURE TO:

- Answer each question or indicate if an item does not apply to your situation
- Sign and date the application
- Have your doctor, nurse, or social worker complete the Medical Information section
- Provide a phone number where you can be reached to answer any additional questions

Please return this application to:

Tough Enough to Wear Pink of Montana
P.O. Box 18085
Missoula, MT 59808

Rev. 12-8-14

PERSONAL INFORMATION

Applicant's Full Name: ______________________________ Date: ____________

Spouse's Full Name: ______________________________
(If you are legally married, you must indicate your spouse's name here. You may explain separations or other living arrangements in the biography section.)

Address: ______________________ Age: _____ Date of Birth: ________

City: ______________________ State: _____ Zip: __________

Phone: Home: __________ Work: __________ Cell: __________

Referred by: ______________________________

Number of people living in your household: ____ Adults ____ Children Ages: ________

Do you rent or own this home? ______________________________

Name & address of your employer ______________________________

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Name & address of spouse's employer ______________________________

____

Type of health insurance (please check all that apply):

- ❑ Private Health Insurance Provider (i.e., BCBS, Aetna, Assurant, Cigna, etc.)
- ❑ Medicaid
- ❑ Medicaid Pending
- ❑ Emergency Medicaid
- ❑ Medicare plus Medicaid
- ❑ Medicare plus other supplemental coverage
- ❑ Federal Breast & Cervical Cancer Treatment Act
- ❑ VA Program
- ❑ Charity Care
- ❑ Other ______________________
- ❑ None

If private insurance indicate name of insurance company, type of plan, and amounts of any co-pays and/or deductibles: ______________________________

____

Are prescription drugs covered? ❑ Yes ❑ No

Name of primary insured and their relationship to you: ______________________________

ASSISTANCE ASSESSMENT

For what purpose are you seeking financial assistance (check all that apply and provide explanation)?

❑ Housing Costs ❑ Utility Costs ❑ Food Costs ❑ Transportation ❑ Child Care

❑ Home Care ❑ Other ____

Explanation: ____

____

____

____

Have you previously applied for assistance from Tough Enough to Wear Pink of MT? ❑ Yes ❑ No

If yes, please indicate date and outcome of your application: ______________________________

____

If you have received any grants or financial assistance from any other group or entity in the last 12 months, please provide the name(s), date(s), and the amount(s): ______________________________

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FINANCIAL INFORMATION

Total Household Monthly Gross Income (from all sources from everyone living in your household)	$
Total Household Liquid Assets (Cash on hand, checking and savings, money markets, CDs, stocks, etc.)	$
Total Monthly Expenses (Housing, utilities, childcare, food, transportation, insurance, medical bills, etc.)	$

Please attach a complete copy of your most recent federal income tax return, including all attachments and schedules. **Please black out all social security numbers.**

BIOGRAPHY

This section is a chance for you to tell your story. Please use the space below and no more than 1 other sheet of paper (if needed) to indicate what your specific circumstances are (duration of your cancer, what immediate needs you have, special work/income limitations, etc.). Also, if the Financial Information section shows that your current income exceeds your expenses, please explain the circumstances.

AGREEMENT AND SIGNATURE

Please read and sign below after you have carefully reviewed your completed application.

By signing this application, I confirm that I am solely responsible for the accuracy of all information contained herein.

I grant permission to the doctors and medical professionals contained herein to discuss with TETWP of Montana any information regarding my breast cancer treatment, diagnosis, prognosis, etc., pursuant to the Authorization submitted with this Application.

I understand that TETWP of Montana will use any information obtained solely for the purpose of considering financial assistance to me and that all of my medical information will be held in strict confidence.

I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release.

Applicant's Signature: ____

Date: __________________________

MEDICAL VERIFICATION
for Grant Application to Tough Enough To Wear Pink of Montana

Patient Name: ________________________________ Date of Birth: ______________

HIPAA Authorization

I authorize ____ (the "Keeper of the Records") to disclose my protected health information relating to my care and treatment for breast cancer as requested below. I understand that signing this Authorization is voluntary and that my treatment may not be conditioned on the signing of this Authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to the Keeper of the Records. I understand that I cannot revoke this Authorization to the extent this Authorization has been relied upon. I understand that information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient. By signing below, I understand and acknowledge the following: I have read and understand this Authorization; I have been given a copy of this Authorization; I am authorizing the Keeper of the Records to use or disclose my health information to the persons and for the purposes identified in this Authorization; and if I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact the Keeper of the Records. A photocopy of this authorization shall be considered as effective and valid as the original. The information requested by this Authorization may be received by Tough Enough To Wear Pink of Montana, P.O. Box 18085, Missoula, MT 59808. The information is being requested for the purpose(s) of awarding a grant for treatment of breast cancer expenses. Unless revoked earlier, this Authorization will expire twelve months after the date of the patient's signature below.

Patient Signature: ____________________________________ Date: ________________________

This section is to be completed and signed **ONLY** by the Applicant's Doctor, Nurse or Licensed Social Worker.

Primary Cancer: ________________________________ Date of Diagnosis: __________

Stage of Cancer: ____

Is this a ❑ New Diagnosis or ❑ Recurrence Is the patient in active treatment? ❑ Yes ❑ No

If Yes, please indicate type of treatment: (please check all that apply)

❑ Chemotherapy ❑ Radiation ❑ Surgery ❑ Bone Marrow/Stem Cell Transplant
❑ Palliative Care ❑ Clinical Trial ❑ Hormonal ❑ Complementary/Alternative

If No, will post-treatment follow-up be required? ❑ Yes ❑ No

Please indicate the frequency of post-treatment follow-ups?

❑ Yearly ❑ Every Six Months ❑ Other ___________________________________

Physician's Name: ____

Address: ____

City/State/Zip: ____

Phone: __________________________ Fax: ______________________

Signature of doctor, nurse, or social worker: _______________________________________

Print Name/Title: ____

Phone (if different from above): _____________________________