Breast and Body's Health Cancer Financial Assistance Application Form

2217 Papermill Rd Winchester, VA 22601

Phone: (540) 313-4705 Fax: (540) 773-4979

To be completed by the patient or an authorized Power of Attorney or a Parent or Guardian if the patient is a minor.

Patient Information

First Name:	MI:	Last Name:	
Date of Birth:	Social Security Number :		
Address:	City:	State:	Zip Code:
Phone:	Email:		

Income Information

Are you employed? Yes □ No □	Do you file Taxes? Yes □ No □
Do you receive Social Security Benefits? Yes □ No □	Do you receive Pension Benefits? Yes □ No □
Gross Monthly Income:	Monthly Expenses:
Household size:	Marital Status: Married □ Separated □ Divorced □ Single □ Widowed □
Do you have a Checking Account?	If Yes how much? $0-$500 □ $501-$1,000 □ > $1,000 □
Do you have a Savings Account?	If Yes how much? $0-$500 □ $501-$1,000 □ > $1,000 □

Diagnosis and Treatment Information

Cancer Diagnosis:

Medication (s) used to treat your cancer	Co-Pay (Patient's responsibility)

Insurance Coverage Information

Do you have Medical Insurance? Yes □ No □	Do you have Prescription Insurance? Yes □ No □
Do you have Medicare Insurance? Yes □ No □	Do you have Medicaid Insurance? Yes □ No □ (Medicaid Spendowns do not qualify)
Have you applied for financial assistance from another charity? Yes □ No □	

Assistance Type (Choose all that apply)

Mammography □	Meal delivery to your home □
Mastectomy/Prosthesis □	Financial Hardship Assistance □
Copays: Medical □ Prescription □	Hope in a bag □
Wigs □	Transportation to Dr's visits □
Gas Card □	Other :

Patient Declaration: By signing this application form, I acknowledge that all the information provided on this form is true and accurate. I understand that I will receive a 1099 tax form if my grant exceeds $599.99 with in 1 year.

Patient Signature: **Date**:

Name of the person completing this application on behalf of the patient

Requestor's First Name: **Last Name**:

Relationship to the patient: Parent/Guardian □ POA□ (Please provide proof of Power of Attorney)

Requestor's Signature: **Date:**

To be completed by an authorized personnel of the Breast and Body Health

Approved for Assistance ? Yes □ or No □	Declination Reason:	
Approved Assistance Type:		
Standard One time assistance □	Extended Assistance□	
Approval Amount: $	Enrollment Period:	