APPLICATION FOR ASSISTANCE

Application Date ______________________________

Are you an OHIO resident? YES_____ NO_______

APPLICANT INFORMATION

Applicant's Name (First & Last) ____

Date of Birth _______________Race______________________ Gender____________________

Home Address: ____

Number, Street (no P.O. Box)

____

City/Town State Zip Code County of Residence

Home Phone: ____

Work Phone: ____

Email Address: ____

Assistance Requested: Self ________ Spouse _____ Parent ______ Child_______________

REFERRAL INFORMATION

Source: (how did you hear about the program?)
Website _____ Friend ______ Other (specify)___________________________

TYPE OF ASSISTANCE REQUESTED

Transportation t/f Treatment _____ Prescription Medication ______ Food Delivery _______

Other (please explain) ____

____

Requested Dollar Amount $____

INSURANCE INFORMATION

Do you have medical insurance? Yes ___No __________
** If yes, you **MUST** attach a copy of all insurance cards.

(Please complete the following insurance information.)

NAME OF INSURANCE (check all that apply)	POLICY HOLDER (self, spouse or parent)	ID#/ GROUP#	EFFECTIVE DATE	EXPIRATION DATE
Medicare ______ Part A__ Part B __ Part D__		ID# Group#	MM/DD/YY	MM/DD/YY
Medicare Advantage Plan ______ Name of Insurance Company		ID# Group#	MM/DD/YY	MM/DD/YY
Medigap ______ Name of Insurance Company		ID# Group#	MM/DD/YY	MM/DD/YY
Private Insurance(1)________ Name of Insurance Company		ID# Group#	MM/DD/YY	MM/DD/YY
Private Insurance(2)_________ Name of Insurance Company		ID# Group#	MM/DD/YY	MM/DD/YY
Military Dependent ________		ID# Group#	MM/DD/YY	MM/DD/YY

What does your insurance cover? (Check all that apply)

Physician Services__________
Hospital Services: Inpatient Care__________Outpatient Care ___________
Prescriptions_______________

OTHER RESOURCES

Please list any other resources needed for breast cancer assistance.________________________
____
____
____
____

FINANCIAL ELIGIBILITY **(Assistance eligibility for Ohio residents only)**

In order to determine your financial eligibility for this program we need to collect information regarding household composition and monthly household income.

PROOF OF INCOME MUST BE ATTACHED. W-2 forms, 2 recent paystubs, Social Security entitlement letter or a notarized letter stating "No Income & No Employment" are acceptable forms of income verification.

HOUSEHOLD COMPOSITION

(Please list the names and ages of all family members who are dependents on your income tax return and indicate their relationship to the patient.

FIRST NAME	LAST NAME	AGE	RELATIONSHIP TO PATIENT
1.			
2.			
3.			
4.			
5.			

If there are more than 5 residing in your household, please attach a separate list of other dependents listed on your income tax return.

Total number of people in household (including patient): ______________________

MONTHLY HOUSEHOLD INCOME

	PATIENT	SPOUSE	DEPENDENT
MONTHLY SALARY (before deductions)	$	$	$
PENSION	$	$	$
SOCIAL SECURITY	$	$	$
RETIREMENT	$	$	$
CHILD SUPPORT	$	$	$
UNEMPLOYMENT	$	$	$
AILIMONY	$	$	$
WORKERS COMP	$	$	$
SOCIAL SECURITY DISABILITY	$	$	$
TOTAL MONTHLY INCOME	$	$	$

PATIENT AGREEMENT

I certify that all of the information on this form is true, correct and complete. I understand that any false statements would result in denial of Financial Assistance Program.

I authorize Breast Health Connect, Inc. to verify any information provided by me on this form. I will provide proof of any information on this form required by the Program.

All information is strictly confidential and is for Breast Health Connect, Inc.'s purposes and use only. Breast Health Connect, Inc. may discuss this information internally through verbal and electronic communications to determine your eligibility for the Financial Assistance Program. If approved, financial assistance will be sent directly to the provider or vendor of services.

Print Name of Applicant____

Signature of Applicant____

Date of Application ____

PLEASE RETURN COMPLETED APPLICATION TO:

Breast Health Connect, Inc.
c/o Application for Assistance
6471 Albany Gate, Unit J
Columbus, OH 43230

For questions, please call Breast Health Connect, Inc. at (301) 887-7611

Please allow 2-4 weeks for the processing of your application.