BREAST CANCER FOUNDATION OF CENTRAL FLORIDA
APPLICATION FOR FINANCIAL ASSISTANCE

Application for assistance is based on current or ongoing hardships of treatment related to breast cancer. Application for assistance will be individually evaluated by our organization after completion of this form and verification from your health care provider concerning your breast cancer status. Please fill this form out completely and call (417) 862-3838 with any questions regarding the application.

First Name	Last Name	Date of Birth
Address	City, State	Zip
County	Telephone	Email
Name of Spouse (if applicable)	Number of Children in Home and Ages	Other Dependents

Medical Diagnosis
_____
_____

Physician	**Health Coverage** ____No ____Yes If yes, Circle TYPE below: Personal Policy Through Employer Medicare Medicaid What is your deductible?_____ Is your premium deducted from your paycheck? Yes No If yes, how much per month_____

Considering your expenses, please list the payments with which we can be of the most assistance:
_____
_____
Please list any other agencies you are currently working with:
_____
Name of Employer (if applicable):
_____

BCFCF pays to invoice only, cash is not provided.

Enclosed is a medical records release form you will need to fill out so that BCFCF can receive information verifying your breast cancer status. I hereby certify that I have been diagnosed with breast cancer and require financial assistance. I also certify that the above information is true and correct. All information is considered confidential and will be used only for eligibility determination. You may be asked to discuss benefits of assistance.

Date:_____ _____
Patient/Family Member/Other

PLEASE RETURN TO: 620 W. Republic Rd, Ste 107, Springfield, MO 65807
-or-
FAX TO: (417) 862-3830

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Financial Information

Monthly Income

Employment	Patient	_____
	Spouse	_____
	Other	_____
Retirement	Social Security	_____
	VA Pension	_____
	Employee Pension	_____
Other Income	Alimony	_____
	Child Support	_____
	Investments	_____
	Public Assistance	_____
	Workman's Comp	_____
	Unemployment	_____
	Disability	_____
	Insurance	_____
	Savings	_____

Monthly Expenses

Rent/Mortgage	_____
Utilities	_____
Food	_____
Insurance- Health	_____
Insurance- Home (monthly or indicate frequency)	_____
Insurance- Car (monthly or indicate frequency)	_____
Medical	_____
Auto Payment (monthly/balance of loan)	_____
Credit Card Debt (monthly and total)	_____
	_____
Other Expenses	_____
	_____
	_____

Assets	**Value**

(If more space needed, please attach separate sheet)