

**CLIENT INFORMATION**

All fields are required. Please provide explanation for incomplete items. Please print.

Patient name (last, first): \_\_\_\_\_ Application Date: \_\_\_\_/\_\_\_\_/2008

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Message Phone: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnicity:

American Indian/Native Alaskan  African American  Asian/Pacific Islander  Caucasian  Hispanic  Other: \_\_\_\_\_

English Speaking?  Yes  No U.S. Resident:  Yes  No (*not an eligibility requirement*)

Stage of Breast Cancer:  Stage I  Stage II  Stage III  Stage IV  Unknown

Residence County: \_\_\_\_\_ Treatment County \_\_\_\_\_

Can Cancer Lifeline contact you about our free programs and services?  Yes  No (*not an eligibility requirement*)

- I give permission for my health care providers to release my contact information and diagnosis to Cancer Lifeline.
- I give Cancer Lifeline permission to communicate with the vendor below regarding assistance transaction details.
- My income or my family income is below the applicable level on the back of this application.

Patient Signature: \_\_\_\_\_

**SOCIAL/HEALTH CARE WORKER INFORMATION**

Name: \_\_\_\_\_ Phone \_\_\_\_\_

Facility Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

- I have verified that the patient/family annual income is below the applicable level (250% of poverty)
- I have verified that health insurance or other programs will not pay for the type of assistance requested below

Social/Health Care Worker's Signature: \_\_\_\_\_

**TYPE OF ASSISTANCE**

Please check one and write amount in the box at right

One request per application

- Rent/mortgage
- Public Transportation (to and from medical appointments only)
- Food and nutritional supplements
- COBRA Insurance premiums
- Medications not available via pharmaceutical assistance funds
- Personal hygiene/specialty clothing items
- Utilities
- Dental care needed prior to chemotherapy
- Childcare
- Medical supplies/treatment such as lymphedema sleeves, physical therapy, etc.

**VENDOR INFORMATION**

Amount: \$ \_\_\_\_\_

Name on Account \_\_\_\_\_

Vendor name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP \_\_\_\_\_

For all categories except Food an appropriate bill or other documentation must accompany applications (e.g. lease, bill, or invoice)

All information is strictly confidential. Funds are limited and based on availability. Incomplete applications will be returned.

Completed applications will be processed in 2-3 weeks. Download application and information at [www.cancerlifeline.org/komen.html](http://www.cancerlifeline.org/komen.html)