



Submit by fax: 206-297-2200

Or

Mail to: 6522 Fremont Ave N.

Seattle, WA 98103

# 2009-2010 Komen Patient Assistance Fund Application Form



## CLIENT INFORMATION

All fields except ethnicity and nationality are required. Please provide explanation for incomplete items. Please print.

Patient name (last, first): \_\_\_\_\_ Application Date: \_\_\_\_/\_\_\_\_/2009

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

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

E-mail: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_\_\_

Ethnicity: Hispanic  yes,  no

Nationality:  American Indian,  Pacific Islander,  African American,  White (non-immigrant),  White (immigrant),  
 Asian,  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: \_\_\_\_\_.

*I hereby authorize my healthcare provider or social worker at \_\_\_\_\_ to disclose diagnosis, financial and family information from my health records to a financial navigator at Cancer Lifeline for purposes of eligibility determination for financial assistance programs.*

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
- I have verified that this client is within 3 months of active breast cancer treatment and does not include hormonal treatment.

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

The Komen Patient Assistance Fund can help with the following:

- Low or fixed-income housing/rent
- Health insurance premiums
- Food gift cards (one time only of \$250)
- Public transportation to and from treatment
- Medication/Nutritional supplements (Ensure, Boost etc.) not available via pharmaceutical assistance funds
- Naturopathic medication (vitamins, minerals, acupuncture, etc.) not covered by insurance
- Utilities
- Dental care required before or after chemotherapy
- Childcare
- Medical supplies/specialty garments, i.e.: Lymphedema sleeves, dressings prosthesis, bras

*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.*