BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED!
APPLICATIONS MUST INCLUDE SUPPORTING DOCUMENTS
NO REIMBURSEMENTS FOR PAID BILLS CONSIDERED

Dear Applicant:

The Breast Cancer Assistance Program (BCAP) provides services to women facing financial challenges. The BCAP program provides financial assistance for but not limited to: ***medical related lodging, co-pay, office visits and prosthesis.*** This program also provides **FREE mammograms** for those who qualify.

Attached are the Application and Physician Verification Form. ***Each form must be completed and submitted with the REQUIRED SUPPORTING DOCUMENTS (i.e., medical bills).*** Upon completion and submission of the forms, the completed application **will take approximately 30 business days to process.**

BCAP is designed to assist breast cancer survivors during treatment- RADIATION or CHEMOTHERAPHY.

It is our goal to assist you financially during your journey. Sisters Network® Inc. is a leading voice and only national African American breast cancer survivorship organization in the United States. Our purpose is to save lives and provide a broader scope of knowledge that addresses the breast cancer survivorship crisis affecting African American women around the country.

***As a Survivor we would like to invite you to connect with one of our local chapters.**

- **Submit a statement of testimony** to infonet@sistersnetworkinc.org upon approval which may be posted on our website.
- **Contact your local Sisters Network Chapter at time of approval and attend a meeting or outreach event.**
  ****If a chapter is located in your area.***

Wellness,
Sisters Network® Inc. National Headquarters

Office Use Only:	
Date Rec'd: _____	Scan Date: _____

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IF APPROVED, FINANCIAL ASSISTANCE PAYMENTS ARE MADE DIRECTLY TO THE PROVIDER. SUBMISSION OF THIS APPLICATION DOES NOT IMPLY OR GUARANTEE APPROVAL OF FINANCIAL ASSISTANCE. PLEASE SUBMIT COPIES OF BILLS.

PERSONAL INFORMATION (PRINT CLEARLY)		
Today's Date:		
Are you a member of a ***Sisters Network Affiliate Chapter***? ☐ Yes ☐ No		If **YES**, what chapter?
First Name:		Last Name:
Date of birth (M/D/Y):	Phone:	Email:
Current address:		
City:	State:	ZIP Code:
Insurance: ☐ Yes ☐ No		If Yes: ☐ Private/Commercial ☐ County/State ☐ Medicaid/Medicare

ASSISTANCE REQUESTED (CIRCLE ONE)		
Have you received BCAP in the last 12 months? ☐ Yes ☐ No		
Office Visit Copay	Medical Related Lodging	Treatment Copay
Mammogram	Other (please describe)	

TREATMENT INFORMATION	
	Age at Diagnosis:
Treatment:	
Are you currently in treatment? ☐ Yes ☐ No	**If YES, Treatment dates: Start:_____ Approximate Finish:_____**
If **YES**, type of treatment:	

FINANCIAL STATUS		
Are you currently employed? ☐ Yes ☐ No		If **NO**, state reason:
List sources of income:		
Amount of Request: $	Head of Household ☐ Yes ☐ No	Number in Household:
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K		
Explain circumstances creating financial need at this time:		

HOW DID YOU HEAR ABOUT SISTERS NETWORK® INC.? (REQUIRED INFORMATION)		
Referred by:		
Did referring Organization give you any assistance?: ☐ Yes ☐ No		
Contact Name	Contact Email	Contact Phone

PLEASE FAX APPLICATION & SUPPORTING DOCUMENTATION TO: 713.780.8998 fax
Or Mail To: Sisters Network Inc. • 2922 Rosedale St. • Houston, TX 77004

Office Use Only:

Date Rec'd: _____ Scan Date: _____

PHYSICIAN VERIFICATION FORM
BREAST CANCER ASSISTANCE PROGRAM (BCAP)

Dear Physician:

Your patient has applied for financial assistance from our organization. In order to complete the enrollment process we must verify the following information with you as the ***prescribing and/or treating physician***. Please contact Sisters Network® Inc. if you have questions.

PATIENT INFORMATION (PRINT CLEARLY)		
		Today's Date:
First Name:		Last Name:----
Date of birth:	Phone:	Email:
Current address:		
City:	State:	ZIP Code:
☐ Check here if applicant is requesting assistance for a mammogram (please send referral and/or prescription)		
Type of Breast Cancer:		
Stage of Breast Cancer:	Treatment:	
Currently in treatment? ☐ Yes ☐ No	**Treatment dates: Start:_____ Approximate Finish: _____**	

PHYSICIAN CONTACT		
Physician Name:		
Organization/Hospital:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:
Office Contact Name:	Position:	Phone (if different):

☐ I certify that the patient named is currently a patient and has been diagnosed with breast cancer and is currently under my care for treatment.

☐ I certify that the above named is currently a patient and has been given a referral and/or a prescription for a mammogram

Health Care Professional/Physician Signature: _____ Date: _____

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