BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

The Breast Cancer Assistance Program **(BCAP)** is designed to assist breast cancer survivors facing financial challenges while undergoing **Radiation or Chemotherapy** Treatment.

BCAP 2015 APPLICATION PERIOD ENDS ON NOVEMBER 13, 2015.

BCAP 2016 APPLICATION PERIOD IS FROM FEBRUARY 1, 2016- NOVEMBER 11, 2016.

To be considered for Financial Assistance, please provide the following:

- ☐ **Completed BCAP Application**
- ☐ **Physician Verification form- Signed**
- ☐ **Copy of Your Identification (Drivers License, State ID, Or Passport)**
- ☐ **Required Email Address: Must be provided to receive progress updates**
- ☐ **Copy of ONE (1) Outstanding Bill:**
  - ☐ **One (1) Utility Bill (MUST be 30 days Delinquent) OR**
  - ☐ **One (1) Medical bills (MUST be 30 to 90 days Delinquent) OR**
  - ☐ **Current Apartment Lease ONLY (MUST be 30 days Delinquent) OR**
  - ☐ **Mortgage Statement (MUST be 30 days Delinquent)**
- ☐ **Financial Assistance Questionaire**
- ☐ **Signed Terms and Conditions**

ASSISTANCE INCLUDES:

- **Utility Bill** (Gas, Water or Electric)
- **Medical Bills** (Hospital/Clinic/Medical Groups/Doctors)
- **Rent**
- **Mortgage**

PLEASE CHECK AGAIN

NO REIMBURSEMENTS FOR PAID BILLS

INCOMPLETE APPLICATION PACKAGE WILL NOT BE REVIEWED
MUST SUBMIT THE ENTIRE APPLICATION PACKAGE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE

- ☑ Completed BCAP Application
- ☑ Completed Physician/Health Care Professional Form
- ☑ Copy of Your Identification (Drivers License, State ID, Or Passport)
- ☑ Required Email Address
- ☑ Copy of One(1) Bill
- ☑ **Financial Assistance Questionaire**
- ☑ **Signed Terms and Conditions**

We would like to invite you to connect with one of the National Affiliate Chapters which can be found at www.sistersnetworkinc.org

PLEASE FAX APPLICATION & OTHER FORMS TO: 713.780.8998 fax
Or Mail To: Sisters Network Inc. • 2922 Rosedale St. • Houston, TX 77004 Email to: Patientnavigator@sistersnetworkinc.org

Office Use Only:	
Date Rec'd: __________	Date Rec'd Assistance: ___________

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

If Approved, Payments are made directly to the Provider.
Submission of this application does not imply or guarantee approval of financial assistance.
APPLICANTS CAN ONLY RECEIVE FUNDING ONCE A YEAR

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 (MM/DD/YYYY):	Phone:	Email:	
Current address:			
City:	State:		Zip Code:
Medical Insurance: ☐ Yes ☐ No	If Yes: ☐ Private/Commercial ☐ County/State ☐ Medicaid ☐ Medicare ☐ Supplemental Insurance A ☐ Suppliemntal Insurance B Name of Insurance Carrier:		

RACE/ETHNICITY INFORMATION: (Check one)

☐ Black or African American
☐ American Indian or Alaska Native
☐ White
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino

ASSISTANCE REQUESTED (PLEASE SELECT ONE)
Please provide the below information to the support the bill you are submitting:

Have you received BCAP in the last 12 months? ☐ Yes ☐ No

What Type?
How Much?

Utilities	FINANCIAL REQUEST	PROVIDER
Medical Bill	FINANCIAL REQUEST	PROVIDER
Rent	FINANCIAL REQUEST	PROVIDER

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Personal Information (Print Clearly)

Mortgage	FINANCIAL REQUEST	PROVIDER

FINANCIAL STATUS

Are you currently employed? ☐ Yes ☐ No	If **Yes**, please name occupation:
If **No**, state reason	
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K+	
Head of Household ☐ Yes ☐ No	Number in Household:

List Sources of Income:

☐ Employment ☐ Child Support ☐ Public Assistance ☐ Family/friends provide support
☐ Social Security(Retirement) ☐ Pension ☐ Disability ☐ Unemployment

Education Level: ☐ Some School ☐GED ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate

PHYSICIAN VERIFICATION FORM BREAST CANCER ASSISTANCE PROGRAM (BCAP)

Dear Physician:

Your patient has applied for financial assistance from Sisters Network Inc.(SNI). In order to complete the application process, the following information is to be verified by you as the ***prescribing and/or treating physician***. Please contact Sisters Network® Inc. if you have questions.

Release of Medical Information

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name (print)____

Patient Signature____

PATIENT INFORMATION (PRINT CLEARLY)

Today's Date:		**Age of Diagnosis:**
First Name:		Last Name:
Date of birth: (mm/dd/yyyy)	Phone:	Email:
Current address:		
City:	State:	ZIP Code:

TYPE OF TREATMENT

Type of Breast Cancer:	Current Stage of Breast Cancer:
Currently in treatment? ☐ **Yes** ☐ **No**	**Treatment dates: Start:__________ Approximate Finish: __________**
Treatment:	

PHYSICIAN CONTACT

Physician Name:		Physician Stamp
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.

Health Care Professional/Physician Signature: ____ Date: ____________________

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Revised 11/05/2015

FINANCIAL ASSISTANCE QUESTIONAIRE
BREAST CANCER ASSISTANCE PROGRAM (BCAP)

Why is your financial request is important to you?

____

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How will granting this request relieve your financial burden?

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How will this financial grant improve your quality life?

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Is there any additional assistance that you are needing? (Transporation, Emotional Support)

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How did you hear about Sisters Network Financial Assistance Program?
(Please be Specific)

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Revised 11/05/2015

Terms and Conditions:

1. **Allocation of Funds:** Sisters Network® Inc.(SNI) Board of Directors allocates certain monies and other resources to the *Breast Cancer Assistance Program* (BCAP) through the annual budget. The number and size granted by the Breast Cancer Program is dependent upon the allocation of Sisters Network resources to the *Breast Cancer Assistance Program* within Sisters Network annual budget. Sisters Network Board of Directors has exclusive determination as to those monies and resources.

2. **Selection Process:** The *BCAP* application, including the selection of the successful applicant is reviewed by the BCAP Survivor Committee. The Survivor Committee meets throughout the year to consider completed and qualifying BCAP Applications. Sisters Network and the Survivors Committee reserve the right to decline a request, and/or partially grant a request based upon the allocation of funds to the program. **REVIEWING OF THIS APPLICATION DOES NOT CONSITIUTE ANY PROMISE OR ASSURANCE BY SISTERS NETWORK (OR ANY OF ITS REPRESENTATIVES) TO AN APPLICANT REGARDING THE GRANTING OF THEIR REQUEST.**

3. **Grants of Rights, Restrictions on Use:** The information provided by applicant herein will only be utilized for Sisters Network® Inc. consideration of your BCAP Application. Your information will not be shared with anyone unaffiliated with Sisters Network. Should your request be granted, Sisters Network will not communicate with any third parties relating to your request without your prior consent. Sisters Network reserves the right to utilize your *Breast Cancer Assistance Program* experience to share with potential sponsors as well as the general public in order to promote the *Breast Cancer Assistance Program* to other women cancer survivors that could potentially participate in this program. Sisters Network reserves the right to terminate the *Breast Cancer Assistance Program* at any time due to budget restraints or unmitgating cirmcumstances.

4. **Time Frame of Process:** The complete review /approval process takes approximately 30 business days from the date that Sisters Network Inc. received the entire BCAP application package.

BCAP 2015 APPLICATION PERIOD ENDS ON
NOVEMBER 13, 2015.

BCAP 2016 APPLICATION PERIOD IS FROM
FEBRUARY 1, 2016- NOVEMBER 11, 2016

I affirm that I have read the all of the above important information, and attest that the information provided by me in this application is true and correct to the best of my knowledge.

Applicant Signature: ____

Printed Name: _________________________________ Date Signed: ___________________

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