A National African American Breast Cancer Survivorship Organization

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

Our Breast Cancer Assistance Program **(BCAP**) is designed to assist breast cancer survivors during **RADIATION or CHEMOTHERAPHY** (*Priority is given to those in active treatment)* who are facing financial challenges in the following areas:

Assistance includes

Mammograms
Medical related lodging
Office Visit / Treatment Co- Pay
Breast Prosthesis (Prescription required)
Rent /Mortgage – (provide a copy of a current lease agreement or mortgage note)
Prescriptions - (Breast Cancer related)
Non - Emergency Medical transportation- Houston and Surrounding Areas
Utilities (Gas, Water and Electric)

- Checklist - Please ensure the following documents are included before submitting package:
  - **Completed BCAP Application**
  - **Physician Verification form- Signed**
  - **Copies of outstanding bills (up to 90 days)**

INCOMPLETE APPLICATION PACKAGE WILL NOT BE REVIEWED MUST SUBMIT THE ENTIRE PACKAGE TO BE CONSIDERED FOR FINANCIAL ASSISTANCE- (THE BCAP APPLICATION, A SIGNED PHYSICIAN VERIFICATION FORM, AND COPIES OF BILLS)

NO REIMBURSEMENTS FOR PAID BILLS

- The complete review /approval process **takes approximately 30 business days** from the date that Sisters Network Inc. received the entire BCAP application package.
- As a Survivor we would like to invite you to connect with one of our national affiliate chapters which can be found at www.sistersnetworkinc.org**.**

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.

Wellness,
Sisters Network® Inc. National Headquarters

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

Revised 05/2015

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

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

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	

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 (CIRCLE ONE)

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

Office Visit/ Treatment Copay	Rent /Mortgage	Hospital/Clinic Bills
Utilities	Explain reason needing financial assistance:	

FINANCIAL STATUS

Are you currently employed? ☐ Yes ☐ No	If **Yes**, please name occupation:
If **No**, state reason	List all Income resources:

Amount of Request: $	Head of Household ☐ Yes ☐ No	Number in Household:
Annual Household Income	☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K+	
Level of Education	☐GED ☐ High School ☐ Some College ☐ College Graduate	

RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of me 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_____

Entity Name:_____

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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:
TYPE OF TREATMENT		
Type of Breast Cancer:		Stage of Breast Cancer:
Currently in treatment? ☐ Yes ☐ No		
Treatment:		**Treatment dates: Start:_____ Approximate Finish: _____**
Additional Comments:		
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.		
Health Care Professional/Physician Signature: _____		Date: _____
HOW DID YOU HEAR ABOUT SISTERS NETWORK INC?		
Referred By:		
Did referring Organization give you any assistance ☐ Yes ☐ No:		
Contact Name	Contact Email	Contact Phone

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