APPLICATION FOR FINANCIAL ASSISTANCE

- Chicks n Chaps® is a non-profit 501(c)(3) tax-exempt organization that provides assistance to individuals with breast cancer.
- You will be notified by certified mail within 90 days as to whether or not your application has been approved.
- All applicants may re-apply after 1 year.
- Grants are based upon availability of funds and the applicant's need.
- Forms of assistance will be decided on a case-by-case basis by the Chicks n Chaps® Care Committee.
- All information is held in the strictest confidence and is used only by Chicks n Chaps® for the purpose of reviewing financial assistance needs. The information required in this application is necessary for us to determine whether granting assistance to you is consistent with our organization's charitable purposes for which we have been granted tax exempt status by the IRS and the State of Montana.
- Chicks n Chaps® Care Committee reserves the right to waive any portion of this application.
- Chicks n Chaps does not discriminate against an individual's age, color, culture, disability, ethnic, gender, marital status, nationality, appearance, race, religion, sexual identity, sexual orientation or social class.

PLEASE BE SURE TO:

- Answer each question or indicate if an item does not apply to your situation.
- Sign and date the application.
- Have your doctor, nurse, or social worker complete the Medical Information section.
- Provide a phone number where you can be reached to answer any additional questions.

Please return application to:

Chicks n Chaps®
PO Box 4442
Missoula, MT 59806

PERSONAL INFORMATION

Applicants Full Name: _____ Date: _____

Spouse's Full Name: _____
(If you are legally married, you must indicate spouse's name here. You may explain separations or other living arrangements in the biography section.)

Address: _____ City: _____

State: _____ Zip: _____ Age: _____ Date of Birth: _____

Phone: _____ Cell: _____ Work Phone: _____

Referred By: _____

Number of people living in your household: _____ Adults: ____ Children (+ages): _____

Do you own this home: Yes or No

Name & Address of Employer: _____

_____

Name & Address of Spouse's Employer: _____

_____

Type of Health Insurance (please check all that apply):

- ○ Private Health Insurance (i.e., BCBS, Cigna, etc.)
- ○ Medicaid
- ○ Medicaid Pending
- ○ Emergency Medicaid
- ○ Medicare plus Medicaid
- ○ Medicare plus other supplemental coverage
- ○ Federal Breast & Cervical Cancer Treatment Act
- ○ VA Program
- ○ Charity Care
- ○ Other _____
- ○ None

If private insurance, indicate name of insurance company, type of plan, and amounts of any co-pays and/or deductibles: _____

_____

Are prescription drugs covered: Yes or No

Name of Primary Insured and their relationship to you: _____

ASSISTANCE ASSESSMENT

For what purpose are you seeking financial assistance?

- ○ Housing Costs
- ○ Utility Costs
- ○ Foods Costs
- ○ Transportation
- ○ Child Care
- ○ Home Care
- ○ Other: _____
  _____

Have you previously applied for assistance from our organization: Yes or No

If yes, please indicate date and outcome of your application: _____

_____

If you have received any grants of financial assistance from any other group or entity in the last 12 months, please provide the name(s) and the amount(s):

Amount of funds requested from Chicks n Chaps®:

FINANCIAL INFORMATION

Total Household Monthly Gross Income: _____
(from all sources from everyone living in your household)

Total Household Liquid Assets: _____
(Cash on hand, checking and savings, money markets, CDs, stocks, etc.)

Total Monthly Expenses: _____
(housing, utilities, childcare, food, transportation, insurance, medical bills, etc.)

Dollar amount that would be beneficial to get you through a month of expenses:

BIOGRAPHY

Please use the space below (and any additional pages) to tell us your story. Indicate what your specific circumstances are (duration of your cancer, what immediate needs you have, special work/income limitations, etc.). And remember, family is important to Chicks n Chaps®, please tell us about your family and loved ones who are also affected by your cancer and treatment.

AGREEMENT AND SIGNATURE

Please read and sign below after you have carefully reviewed your completed application.

By signing this application, I confirm that I am solely responsible for the accuracy of all information contained herein.

I grant permission to the doctors and medical professionals contained herein to discuss with Chicks n Chaps® any information regarding my breast cancer treatment, diagnosis, prognosis, etc., pursuant to the Authorization submitted with this application.

I understand that Chicks n Chaps® will use any information obtained solely for the purpose of considering financial assistance to me and that all of my medical and financial information will be held in strict confidence.

I understand that assistance approvals may sometimes result in general information being released and that my name will never accompany such release.

Applicant's Signature: _____ Date: _____

MEDICAL VERIFICATION

For Grant Application to Chicks n Chaps®

Patient Name: _____ Date of Birth: _____

HIPAA Authorization

I authorize _____ (the "Keeper of the Records") to disclose my protected health information relating to my care and treatment for breast cancer as requested below. I understand that signing this Authorization is voluntary and that my treatment may not be conditioned on the signing of this Authorization. I understand that I have the right to revoke this Authorization at any time by providing a signed, written notice of such revocation to the Keeper of the Records. I understand that I cannot revoke this Authorization to the extent this Authorization has been relied upon. Understand that information released pursuant to this Authorization may no longer be protected by law or regulation and may be redisclosed by the recipient. By signing below, I understand and acknowledge the following: I have read and understand this Authorization; I have been given a copy of this Authorization; I am authorizing the Keeper of the Records to use or disclose my health information to the persons and for the purposes identified in this Authorization; and if I have any questions about disclosure of my protected health information pursuant to this Authorization, I may contact the Keeper of the Records. A photocopy of this authorization shall be considered as effective and valid as the original. The information requested by this Authorization may be received by Chicks n Chaps®, PO Box 4442, Missoula, MT 59806. The information is being requested for the purpose(s) of awarding a grant for treatment or breast cancer expenses. Unless revoked earlier, this Authorization will expire twelve months after the date of the patient's signature below.

Patient Signature: _____ Date: _____

This section is to be completed and signed ONLY by the Applicant's Doctor, Nurse or Licensed Social Worker.

Primary Cancer: _____ Date of Diagnosis: _____

Stage of Cancer: _____

Is this a (circle one): NEW DIAGNOSIS or RECURRENCE

Is the patient in active treatment (circle one): YES or NO

If Yes, please indicate type of treatment: (please check all that apply)

- ○ Chemotherapy
- ○ Radiation
- ○ Surgery
- ○ Bone Marrow/Stem Cell Transplant
- ○ Palliative Care
- ○ Clinical Trial
- ○ Hormonal
- ○ Complementary/Alternative

If No, will post-treatment follow-up be required (circle one): YES or NO

Please indicate the frequency of post-treatment follow-ups:

- ○ Yearly
- ○ Every Six Months
- ○ Other: _____

PHYSICIAN INFORMATION

Physician Name: _____

Address/City/State/Zip: _____

Hospital/Clinic: _____ Phone: _____ Fax: _____

Signature of Doctor/Nurse/Social Worker: _____

Print Name & Title: _____