



PATIENT ASSISTANCE

SO NO WOMAN HAS TO CHOOSE BETWEEN BASIC NEEDS AND BREAST CANCER TREATMENT



APPLICATION FORM FOR HEALTHCARE PROVIDERS & SOCIAL WORKERS

Applicant Name: _____ DOB: _____

Address: _____

Email: _____ Call Back Number: _____

Today's Date: _____ English Speaking: Yes No If no, what language: _____

Race/Ethnicity: African American American Indian/Alaskan Native Asian/Pacific Islander

Caucasian Hispanic Multi-racial Decline to answer

Do you live in Multnomah County? Yes No Age: <40 40-64 65+

DIAGNOSIS INFORMATION

Diagnosis: _____ Date of Diagnosis: _____

Physician: _____ Physician's Phone: _____

Treatment Facility: _____

Insurance: Yes No Provider: _____

IDENTIFIED NEED

Describe the need _____

INCOME VERIFICATION

Please list your gross household income per month: _____

Number of People in Household: _____

Primary Source of Income: _____ Amount: _____

Other Income: _____ Amount: _____

Other Income: _____ Amount: _____

Cash Assets should be < \$2,000 for one person or <\$3,000 for two persons

Estimated cash assets: _____

To qualify for the Komen Patient Assistance Program, gross house-hold income must not exceed these limits:

Family Size	Annually	Monthly
1	\$27,225	\$2,269
2	\$36,775	\$3,065
3	\$46,325	\$3,860
4	\$55,875	\$4,656
5	\$65,425	\$5,452

APPROVAL TO SHARE INFORMATION

The Komen Patient Assistance Program is funded by Susan G. Komen for the Cure® and administered by Catholic Charities. In order to determine whether you are eligible to receive assistance, Susan G. Komen for the Cure®, Catholic Charities, and your social worker must receive and share the information on this form. In addition, the information must be verified through contacts with your health care provider(s) and vendors for financial assistance. The information in this application will be used by Catholic Charities solely with respect to the Komen Patient Assistance Program. Susan G. Komen for the Cure® may contact you to assess the quality of services you have received and to evaluate the Komen Patient Assistance Program. Aggregated data (data that does not identify you personally) may be used by Catholic Charities and Susan G. Komen for the Cure® without restriction. I hereby consent to the uses listed above and authorize the contacts listed above.

Applicant Signature: _____ Date: _____

SOCIAL WORKER /HEALTH CARE PROVIDER INFORMATION

Name: _____ Phone: _____

Facility Name: _____ Email: _____

- I have verified that the patient/family annual income is below 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 14 months from the date of breast cancer diagnosis or reoccurrence.

Social Worker /Health Care Provider Signature: _____ Date: _____