THE CATHERINE H. TUCK FOUNDATION
Financial Aid for Women with Breast Cancer

CATHERINE FUND
FINANCIAL AID APPLICATION
Winter 2019

1266 W. Paces Ferry Rd. NW, #421
Atlanta, GA 30327
www. catherinefund.org
email: info @catherinefund.org
fax: (888) 411-5598

GUIDELINES/ QUALIFICATIONS FOR APPLICATION

Please read all Guidelines, Policies and Procedures, and Instructions before completing application. You must meet all guidelines for your application to be considered.

1. You need to be in active treatment for breast cancer which we define as being within three months of a breast cancer surgery (lumpectomy or mastectomy), radiation or chemotherapy (not oral). Applications cannot be considered until qualifying treatment has been started. Hormone therapy does not qualify.
2. **You must be able to provide legal documentation that you have worked (a minimum of 16 hours per week) for at least 8 of the 12 months prior to your most recent breast cancer diagnosis.**
3. You must have a financial hardship as a direct result of breast cancer diagnosis and treatment.
4. You must have less than $5000 in liquid assets.
5. You must be a legal US Citizen currently living in the United States.
6. **Meeting the guidelines and applying to the Catherine Fund does not guarantee a grant will be available or offered.**

POLICIES AND PROCEDURES

1. **This completed application must be received by TCHTF by January 25, 2019 to be considered for a grant.**
2. **Please allow approximately 4 weeks for the application review process once all requested documents have been submitted.**
3. **All grant notification and follow-up is done via email. Applications submitted without a legible email address included will be considered incomplete and not reviewed.**
4. **Applications missing required support documentation will be considered incomplete. Incomplete applications will not be reviewed**.
5. **Funds are limited and grant amounts are based upon current funding availability as well as applicant's needs.**
6. TCHTF will not reimburse for bills that have already been paid by the applicant.
7. TCHTF is not responsible for any fees accrued because of late payments or termination of services.
8. TCHTF reserves the right to refuse service to anyone.
9. Any untrue or falsified information on an application will result in disqualification or termination of aid.
10. TCHTF makes grants for food, housing, utilities, and transportation only. Acceptable utility bills for utility grants are for: electricity, gas, propane, or water. Phone, cable, or internet bills do not qualify. We also accept bills for auto loans or auto insurance.
11. TCHTF does not permit the use of the organization's name or logo without permission.
12. Type and amount of assistance will be determined on a case by case basis by TCHTF.
13. TCHTF will pay bills directly for a grantee. No checks will be written directly to grant recipient.
14. You are only eligible to receive one grant every 12 months.
15. Grant offers are only valid for 90 days after the offer is made, and will not be honored after that date.

_____initials _____date

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INSTRUCTIONS AND CHECKLIST FOR APPLICATION

(please read before completing application)

APPLICATION INSTRUCTIONS (Pages 1-6)

- ☐ **Complete pages 1-6 of the application.** Make sure every page is completed, initialed, and dated.

Include the following documentation with your application:

- ☐ **Documentation of Identity-REQUIRED** Submit a copy of one of the following: your driver's license, birth certificate, State ID, or US passport. The copy must be lightened and legible.
- ☐ **Tax Return – REQUIRED.** Submit a copy of your most recent tax return (Just the first two pages of your 2017 1040 or 1040 EZ form). If you don't have a copy of your return, you can request a free copy of your tax return transcript from the IRS by calling (800) 829-3676. If you are married but file separately, please submit both your return and your spouse's return as well. Black out your social security number on any documents submitted. If you are self- employed, include your Schedule C with your tax return.
- ☐ **W-2(s). –REQUIRED.** Submit copies of all W-(s) that were submitted with the tax return(s).
- ☐ **Employment Documentation. REQUIRED.** Submit some form of documentation that demonstrates you were employed (working at least 16 hours per week) for at least 8 of the 12 months prior to your initial breast cancer diagnosis. Documentation examples include: a letter from your employer or former employer, a W-2, paycheck stubs.
- ☐ **Housing agreement-REQUIRED.** Submit a copy of your rental agreement, lease, or mortgage statement.

If applicable to you:

- ☐ If you are working reduced hours because of treatment, please also submit copies of the past two months of paycheck stubs.
- ☐ If you are on a leave from work, please also provide documentation of your leave and/or benefits.
- ☐ If you receive government aid (i.e. social security, food stamps, and/ or disability), please provide a copy of your benefits letter.
- ☐ Please include any needed explanation of your income situation on page 5 of application. You may add additional pages if needed.
- ☐ **Optional utility bill.** If you are requesting help with utilities or transportation, please also submit a copy of your most recent utility or auto loan/auto insurance bill. (No phone, cable, wireless, or internet bills)

MEDICAL FORM DIRECTIONS (Pages 7-9) REQUIRED

- ☐ Fill out Section 1 of the Medical Report (page 7) and both pages of the Authorization for Release of Information (pages 8-9), and give all three pages to your treating doctor to complete.
- ☐ Request a letter on the doctor's letterhead stating that you are currently under his/her care for breast cancer. Your application is not complete and cannot be considered until a completed Medical Report and letter have been received by TCHTF.

When you submit your application packet:

- ☐ Submit pages 1-6, completed medical form (page 7), letter from the doctor, and supporting documents all together to TCHTF via fax or US mail only. We will not accept applications that are emailed or efaxed to our email address. Applications missing information or required supporting documents will not be reviewed.
- ☐ Check your email weekly for any follow-up questions. **A completed application takes 4-6 weeks to review.**

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APPLICANT CONTACT INFORMATION (please print clearly)

First Name_____ M.I.____ Last Name_____

Address_____Apt.#_____

City_____ State _____Zip Code_____

Date of Birth (MM/DD/YYYY) _____/_____/_____ Age_____ Phone (_____) _____

***An email address is required for all follow-up communication. Please check your email weekly during the application process. You may appoint someone else as your email contact person if you don't have email access.**

Email _____ *** REQUIRED (Please print very clearly, we only communicate with applicants via email, so if we can't read your email address, you may not hear from us.)

Name of email account holder (if not applicant):_____ __

Relationship to applicant:_____.

ADDITIONAL INFORMATION

1. How did you hear about our Catherine Fund Grant Program? _____
2. Ethnicity (optional, for data collection purposes only) _____
3. Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated (please check one)
4. Health Insurance: ___HMO ___PPO ___Medicare ___MediCal ___Medicaid ___Medi-Medi ___BCCTP___ None ___ Other (please check all that apply).
5. Date of initial breast cancer diagnosis_____
6. Are you a US citizen, living in the United States? _____
7. Did you file a tax return for 2017? ___yes ___no. Please follow the instructions for submitting tax returns.
8. If you didn't file a tax return for 2017, what was the most recent year you filed a tax return? _____
9. Please circle the type of assistance you are requesting at this time: (only one will be granted)
   Food/groceries Utilities Housing: Rent/Mortgage Transportation
10. What household expenses concern you most at this time? _____
11. Who do you make your housing payment out to? _____

_____initials _____date

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APPLICANT INFORMATION continued.

12. Do you currently have more than $5000 in liquid assets (including all bank accounts and investment accounts)? _____yes _____no
13. Have you applied to this program before? Name on prior application if different)_____
14. Number of your children_____ Number of your children living with you_____

Name of Child	Age	Gender (M/F)
1.		
2.		
3.		
4.		
5.		

Total Number of People Living in your household_____ Number of wage earners in your household_____

EMPLOYMENT (must be completed) Please see the list of qualifications on page 1 to be sure you meet requirements prior to applying

1. Have you worked at least 8 months out of the 12 months prior to your diagnosis? ____yes____no. (Please see application instructions and provide documentation.)
2. Are you currently employed? _____ If yes, how many hours a week are you currently working? _____
3. Job Title _____ Pay Rate_____
4. If you are not working now, what is the date that you were last employed at least 16 hours per week?_____
5. Job Title_____ Pay Rate_____ Hours per week_____
6. Have you taken a leave under FMLA (Family Medical Leave Act)?_____ If yes, list dates of leave_____
7. Are you currently receiving any government benefits (i.e. food stamps, SSI, SSD, unemployment, etc.)? _____ If yes, please submit documentation of benefit amounts.
8. Are you receiving or have you applied for disability benefits through your employer?____ If yes, please provide documentation of benefit amount or status.

_____initials _____date
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HOW HAS BREAST CANCER TREATMENT AFFECTED YOUR WORK SITUATION AND FINANCES? (Please type or print clearly in ink)

_____initials _____date

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FINANCIAL STATEMENT

Sources of Monthly Income	**Monthly Amount**
Your current monthly wages/salary (after taxes)	$
Your spouse's/partner's monthly wages (after taxes)	$
Property rental income (*not your rent expense)*	$
Interest/Dividends	$
Veteran's Benefits	$
Roommate/Boarder	$
Disability (State or employer)	$
SSI/SSD/SS	$
Unemployment Insurance	$
Worker's Comp	$
Child Support/Alimony	$
State/County Assistance	$
Food Stamps	$
Pension/Retirement	$
Other	$
Total of all Income (Monthly) (*please enter total*)	$
Monthly Expenses	Monthly Amount
Rent or Mortgage (Please circle one)	$
Electricity	$
Gas (home)	$
Water	$
Trash	$
Cable	$
Home Phone	$
Cell Phone	$
Food	$
Auto Loan(s)	$
Auto Insurance	$
Gas (auto)	$
Health Insurance premium	$
Medicines	$
Other	$
Other	$
Total Monthly Expenses (*please enter the total*)	$

I have examined the above statements and certify that, to the best of my knowledge, they are full, true and accurate statement of fact. I understand this application must be received by **January 25, 2019** to be considered.

_____ _____ _____

Applicant Signature Printed Name Date

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MEDICAL REPORT

The patient listed below has applied for financial aid from The Catherine H. Tuck Foundation's "Catherine Fund". A signed Authorization for Release of Information is attached.

Please complete this form and include a letter on the treating doctor's letterhead indicating that this patient is currently receiving care for breast cancer. Applications for aid cannot be considered without a completed Medical Report and letter from their doctor.

Section 1- To be completed by the applicant	
Patients Name First Name:	Last Name:
DOB (mm/dd/yyyy)	Patient ID# (if applicable):
Email:	Cell Phone:
Physician's Name:	Surgeon/Oncologist/Radiologist (circle)
Physician's Address:	
Physician's Phone #:	fax:
Email:	
Section 2- To be completed by the physician, nurse, or medical social worker	
Diagnosis:	Date of initial diagnosis:
Stage : Grade:	
Surgery (specify type)(not biopsy):	Date of surgery:
Chemotherapy (not oral, not hormone therapy) start date Type:	expected end date
Radiation Start date	Expected end date
Contact person Name:	Title:
Phone:	Email:
Physician's Signature	Date:

AUTHORIZATION FOR RELEASE OF INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.

I. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. *I understand that this authorization is voluntary and that I may refuse to sign this authorization, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.*

Patient name: _____ ID Number: _____

A. Persons/organizations authorized to **disclose** the information: _____

_____

B. Persons/organizations authorized to **receive** and use the information:_____

The Catherine H. Tuck Foundation

C. Specific **description of information** to be used or disclosed (including date(s)): ___

diagnosis, treatment plan with anticipated start and end dates

D. Specific **purpose of the disclosure**: *To apply for a grant of financial aid from The Catherine H. Tuck Foundation at the request of the individual*

E. Will the health care provider or health plan requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? No___X___ Yes (describe) _____

F. This authorization will expire January, 2020

(The next page contains important information about your privacy rights.)

AUTHORIZATION FOR RELEASE OF INFORMATION

II. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.

- I may inspect or obtain a copy of the health information described on this form upon request.

- Receipt of my health care benefits (enrollment, treatment, or payment) is not conditioned on my signing this form, or refusing to sign this form.

- Federal confidentiality law (HIPAA) does not prohibit re-disclosure, by the receiving entity, of the information that is used or disclosed pursuant to this authorization. However, California law prohibits the entity receiving my health information from making further disclosure of it, unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law, and I have the right to seek assurances from the receiving entity that they will not re-disclose the information to any other party without my further authorization.

III. Signature of Patient or Patient's Representative

_____ _____

Signature of patient or patient's representative Date

(Note: This form MUST be completed before signing.)

Printed name of the patient's personal representative: _____

_____

Relationship to the patient, including authority for status as representative: _____

_____