Hooked on Hope Treatment Support Grant Application (2018) V4 (Updated 8/22/2018)

Serving the Following Counties: Citrus, Hernando, Hillsborough, Manatee, Pasco, Pinellas, Polk, Sarasota)

General Information:

Patient Name: _____/_____/_____

(Last) *(First)* *(Middle)*

Other Name Known As: _____/_____/_____

(Last) *(First)* *(Middle)*

Email Address: _____@ _____

SS#: _____ **Telephone:** _____ _____ _____

(Home) **(Cell)** **(Work)**

Address: _____

(Street) **(Apt/Unit #)**

_____

(City) **(State)** **(County)** **(Zip Code)**

Date of Birth: _____ **Current Age:** _____

Marital Status: _____ *Married* _____ *Single* _____ *Divorced* _____ *Widowed* _____ *Domestic Partnership*

Number of People Living in Your Household: *Total:* _____ *# Adults:* _____ *# Children (Under 18):* _____

Referral & Support Contacts:

Who Referred You to Hooked on Hope (Please include name, organization, and contact information): _____

_____

Do You Have a Social Worker, Case Manager, or Other Medical Professional You Are Working With: If So, Who: May We Contact Them? _____

Source of Income, Health Insurance & General Information:

Your Primary Source of Income:

Employed: YES _____ NO _____ **(You will report your earning elsewhere in this application)**

Retired/Medicare: YES _____ NO _____ **(You will report your earning elsewhere in this application)**

SSI (Disability): YES _____ NO _____ **(You will report your earning elsewhere in this application)**

Employment Loss of Income:

If you work, do you have sick time, vacation time, or short/long-term insurance available? _____ YES _____ NO

If employed, have you lost or will you lose income because of undergoing breast cancer treatment? _____ YES _____ NO

If yes, please explain (i.e. taking unpaid time off from work to undergo treatment, on FMLA/unpaid medical leave, self-employed):

_____

If yes, will you be returning to work? YES _____ **NO** _____ **When: (Month/Year):** _____ _____

Health Insurance:

Are You Covered By Health Insurance: YES _____ NO _____

If Yes, Type of Health Insurance (i.e. through employer, through self-employment, through Government Plan, Medicaid, Medicare):

_____

NOTE: You will be asked to provide specific financial information (household income and expenses) further in this application.

Breast Cancer Treatment:

Please Tell Us About Your Breast Cancer Treatment Journey:

Date You Were Initially Diagnosed with Breast Cancer (Month/Year): _____ _____

Month **Year**

Treatment(s) You Have Completed or Will Undergo in the Future:

Surgery: (Lumpectomy, Single Mastectomy, Double Mastectomy, 1st Phase Reconstruction): **YES _____ NO _____**

Date(s): _____

Location of Hospital/Surgery Center: _____

Name of Surgeon: _____

Reconstructive Surgery: **YES _____ NO _____**

Date(s): _____

Location of Hospital/Surgery Center: _____

Name of Surgeon: _____

Chemotherapy: **YES _____ NO _____**

Date(s): _____

Location of Clinic/Doctor's Office_____

Name of Physician: _____

Radiation Therapy: **YES _____ NO _____**

Date(s): _____

Location of Clinic/Doctor's Office: _____

Name of Physician: _____

Lymphedema Therapy: **YES _____ NO _____**

Date(s): _____

Location of Hospital/Therapy Office: _____

Name of Therapist: _____

Recurrence Treatment: **YES _____ NO _____**

Date(s): _____

Location: _____

Medical Provider's Name: _____

Other Treatment: **YES _____ NO _____**

Date(s): _____

Location: _____

Medical Provider's Name: _____

Finances Overview & Detailed Information:

Please Tell Us About Your Household Income & Expenses:

HOUSEHOLD MONTHLY INCOME Number of People Living in Your Household: _____

Monthly Net Earnings (Self): $ _____ **Past 12 Months Net Earnings (Self): $ _____**

Monthly Net Earnings (Spouse): $ _____ **Past 12 Months Net Earnings Spouse): $ _____**

Monthly Net Earnings (Other): $ _____ **Past 12 Months Net Earnings (Other): $ _____**

Monthly Net Earnings From Child Support, Alimony, Rental Property, Etc.: $ _____

(For Other Household Income, Please Explain): _____

NOTE: You Must Report Income From ALL Members Living in Your Household)

Do You or Your Spouse Own Property Other Than Your Primary Residence: _____ YES _____ NO If yes, List/Explain:

A. TOTAL NET MONTHLY HOUSEHOLD INCOME: $ _____

HOUSEHOLD MONTHLY EXPENSES Number of People Living in Your Household: _____

Rent/Mortgage Payment: $ _____ **Phone(s): $ _____** **Cable: $ _____**

Electric/Gas: $ _____ **Water/Sewer: $ _____** **Food: $ _____**

Auto Payment: $ _____ **Auto Fuel: $ _____** **Auto Insurance $ _____**

Property Insurance: $ _____ **Property Tax: $ _____** **Life Insurance: $ _____**

Health Insurance: $ _____ **Alimony: $ _____** **Child Support: $ _____**

Other Medical Expenses: $ _____

Other Expenses: $ _____

B. TOTAL NET MONTHLY HOUSEHOLD EXPENSES: $ _____

Financial Need:

What bills do you require assistance with as a *direct result* of undergoing treatment for breast cancer? Do you have new bills or expenses *not usually included in your household budget* because of undergoing treatment for breast cancer?

Examples: (medical office visit co-payments, hospital or outpatient surgery co-payments, prescriptions, lymphedema sleeves, breast garments or prosthetics) NOT covered under your health insurance plan(s):

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Additional Information.

Is there any other information you wish to share with the Grants Review Committee?

_____
_____
_____
_____

Applicant Statement: **I certify that all the information I have provided in order to apply for financial assistance is true, complete and correct. I expressly authorize, without reservation, the Hooked on Hope Breast Cancer Treatment Support Grants Program and its advisors or representatives to contact and obtain information in order to verify the accuracy of information provided by me in this application. I understand that I will be required to provide backup documentation to Hooked on Hope or its representatives in order to verify the information provided herein. I understand that any information that may not be verified, is incomplete, or misrepresented in any respect will be sufficient cause to eliminate me from consideration from financial assistance and will result in the denial of this application. Do not sign until you have read the above application statement. I certify that I have read, fully understand and accept all terms of the foregoing application statement: I understand that my application may not be submitted to the Hooked on Hope Grants Review Committee for consideration unless it is completed in its entirety and required/requested backup documentation has been provided.**

Applicant/Patient Signature: _____ **Date:** _____

PLEASE SCAN & EMAIL THIS COMPLETED APPLICATION, ALONG WITH SIGNED HOOKED ON HOPE GRANT GUIDELINES AND BACKUP DOCUMENTATION TO: hookedonhopegrants@gmail.com