AFRICAN AMERICAN BREAST CANCER ALLIANCE, INC.

'Lil Help, a 'Lil Hope"
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Dear Applicant,

Thank you for contacting the African American Breast Cancer Alliance (AABCA) for help in your breast cancer treatments. AABCA's mission is to provide information and support services to Black/African Americans diagnosed with and affected by breast cancer through our Breast Cancer Survivor Support Program (BCSS).

The cost of care creates a financial burden that can affect patients with limited income and resources. Financial support is provided through our Financial Assistance Program, **"A 'Lil Help, A 'Lil Hope" Fund" (LHLH)**. The fund offers limited **One-Time** grants for non-medical needs to adult breast cancer patients and survivors in current cancer treatments impacted by a lack, loss or reduction of income, health insurance, COVID-19 and experiencing financial stress due to breast cancer treatments. Grants are based on available funds and eligibility determined by the BCSS Board of AABCA, Inc.

PROGRAM INFORMATION and QUALIFICATIONS

Our fund provides **ONE-TIME** financial support:

Amounts of $100 to $500 maximum for patients newly diagnosed, a recurrent diagnosis, metastasis that are in active breast cancer treatments experiencing financial stress, a lost employment, all or part of their income, insurance, and housing and affected by other issues such as COVID-19.

- All information about your breast cancer diagnosis, treatments and care verified with your oncology care providers and kept confidential by AABCA.
- Copy of ALL priority bills you wish considered for payment that are current or past due.
- Priority for grant approval will be extended to those individuals demonstrating the highest level of financial need.
- AABCA mails payments directly to your creditors/service vendors. Applicants will receive a confirmation of payment by mail or e-mail. Payments are NOT mailed to the patient directly.
- The LHLH fund is not an emergency fund and patients are encouraged to seek other resources.
- Application processing is 45 to 60 days
- Both the patient and the medical provider will be notified of the application determination.

Patient Requirements:

- Breast cancer diagnosis within the last 30 months
- Active treatment for stages 0 – 4 breast cancers, early stage to metastasis
- Breast cancer confirmed by physician
- Needs financial help during cancer treatments
- Open to Minnesota, U.S., Wash DC residents.

Active Cancer Treatments confirmed by the doctor/cancer care provider:

- Daily, weekly, bi-monthly, and/or monthly periods of currently administered therapies and treatments that include the following:

Chemotherapy	Radiation	Surgery	Hormone Therapy	Immunotherapy
Clinical Trials	Palliative care	Hospice	Other treatments per doctor	

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- **To be considered for Financial Assistance, please provide the following:**

☐ Completed and signed LHLH Application *(Pages 3 to 5)*
☐ Completed and signed Cancer Care/Medical Providers Information form *(Page 6)*
☐ Copy of bills/invoice (limit of 3) for designated payment to the vendor with company/vendor name and address, and account number.

APPLICATION INSTRUCTIONS: (PDF format)

☐ **To apply:**

1. Print, complete and sign the application.
2. Have your physician complete and sign the MEDICAL INFORMATION form
3. Mail both forms with a copy of your bills/invoices for payment and mail to: **AABCA LHLH Fund, PO Box 8981, Minneapolis, MN 55408**, or
4. Scan all attached completed forms and Email to **grants@aabcainc.org** .

❖ To ensure timely processing of your request for assistance, please fill out all sections of the application completely (pages 3 – 6) and include a clear copy of your bill/invoice(s).

- Please allow up to 60 days for application reviews and notification.
- Incomplete applications will not be processed.
- Applications are collected on a first come, first serve basis and dependent on available funds.
- If approved, a member of our grant support team will contact you by email.
- Payment will be mailed directly to the service provider by check, with a copy of the invoice and a letter confirming payment. Checks are not made payable to the patient.

If you have any questions please call, phone # 612-462-6813 or email us at info@aabcainc.org

KEEP PAGES 1 and 2 FOR YOUR INFORMATION

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Date: _____

Person completing this application ☐ Patient ☐ Family/Friend ☐ Healthcare Professional

Print Name: Signature Date

1. Patient Information

Last Name First Name MI Birthdate

Address/Apt.# City State Zip County

Phone #s Email Address

Gender ☐ Female ☐ Male ☐ Veteran Marital Status: Ethnicity (optional):

2. Cancer Diagnosis and Active Treatment Status

Type	Year	Type	Year

Cancer Stage ☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ Recurrent ☐ Remission ☐ Non-Specified

Current Treatment(s) ☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Immunotherapy ☐ Bone Marrow Transplant

☐ Hormone Maintenance Therapy ☐ Palliative Care ☐ Hospice ☐ Alternative Treatment

Which would be your most important need for financial assistance or resources while currently treated for cancer?

- ☐ Housing (Mortgage/Rent)
- ☐ Medical Co-Pays, Deductibles
- ☐ Utilities (Electricity, Gas, Telephone, Water)
- ☐ Bras, Prostheses, Sleeves, Wigs
- ☐ Food/Meals delivery (MN only)
- ☐ Transportation (MN only)

3. Current cancer journey hardships, and life status

☐ Lost job ☐ Medical bills ☐ Lost housing ☐ Lost income ☐ Childcare needs

☐ Lost health insurance ☐ New cancer diagnosis ☐ Lost caregiver, PCA ☐ Food Insecurity ☐ Transportation needs

☐ Cancer treatments changed, delayed or missed ☐ Diagnosed with COVID-19 Other life issues:

Have you sought local services for: ☐ Cancer Legal Care ☐ Financial Cancer Care

How did you learn about AABCA's Financial Assistance Program?

- ☐ AABCA.org Website
- ☐ Cancer Survivor
- ☐ Family/Friend
- ☐ Patient Navigator
- ☐ Nurse/Social worker
- ☐ Doctor
- ☐ Facebook/Social Media
- ☐ Another agency *(specify)*:

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4. Cancer Center, Hospital, Clinic Information

(Print Clearly)	*NAME and ADDRESS*	*PHONE #*
Oncologist (Primary):		
Hospital/Cancer Center:		

OPTIONAL: ***Other Providers - Optional***

Radiation Care Facility:

Primary Care Clinic:

Primary Care Physician:

Nurse Navigator:

Care Coordinator:

Social Worker Name:

5. Income Information

☐ Employed ☐ No ☐ Yes Employer:

☐ Health Insurance ☐ No ☐ Yes Company

Annual Income ☐ Under $20,000 ☐ $20,001 - $40,000 ☐ $40,001 - $60,000

6. Household Information

☐ Owner ☐ Renter ☐ Share housing ☐ Stable ☐ Temporary ☐ Unstable ☐ Homeless

Do other people live in your home or place of residence? ☐ Yes ☐ No ☐ Children ☐ Adults Over age 18 ☐ Elderly

7. Please share more information about your cancer experience(s):

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8. Financial Assistance Request

Pay and Mail to Address **Amount**

- ***Note:*** **Attach a copy of your bill(s), invoice(s) or statements with your application for creditor/vendor payment determination.**
- **Payment and invoice stub will be mailed directly to the billing company/vendor**

☐ **Mortgage** **Account #**	Pay To, Address	$
☐ **Rent/Landlord** Account #	Pay To, Address	$
☐ **Electric Company** Account #	Pay To, Address	$
☐ **Gas Company** Account #	Pay To, Address	$
☐ **Telephone Company** Account #	Pay To, Address	$
☐ **Water Company** Account #	Pay To, Address	$
TOTAL (limited to $500.00)		**$**

9. Consent of Patient

- ☐ I affirm that I have read all of the application requirements, declare that the information provided by me in this application is correct and true to the best of my knowledge.
- ☐ I understand that all information submitted is confidential and used only for determining eligibility, demographics, and processing of this grant request.
- ☐ I will deliver the medical verification form to my cancer care/medical provider for completion.
- ☐ I authorize my medical provider(s) to provide the required information regarding my breast cancer diagnosis and treatments to AABCA by e-mail, USPS mail or telephone for verification.
- ☐ I understand that each application is reviewed on a case-by-case basis, and African American Breast Cancer Alliance (AABCA) will make the final decision.

- ☐ Please add my contact information to the AABCA mailing list for future events and news.

Applicant Signature	Date

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MEDICAL INFORMATION FORM

Date _____

Dear Cancer Care/Medical Provider:

Please complete the oncology, treatment and patient status information for AABCA's Financial Assistance Program (FAP) "A 'Lil Help, A 'Lil Hope" Fund applicant below who has applied for financial assistance. Please return the medical information form to the patient and/or the African American Breast Cancer Alliance, Inc. (AABCA) by E-mail **grants@aabcainc.org** or USPS mail **AABCA LHLH Fund, PO Box 8981, Minneapolis, MN 55408**.

Please contact AABCA at (612) 462-6813 if you have questions.

Cancer Patient, Survivor Information

Last Name	First Name	MI	Birthdate

Address/Apt.#	City	State	Zip	County

Primary Phone #	Email Address

Current Treatments (please check all that apply)

Type of Cancer(s): Stage

☐ Chemotherapy Date	☐ Radiation Date	☐ Surgery Date	☐ Immunotherapy Date	☐ Bone Marrow Transplant Date

☐ Hormone Therapy Date	☐ Targeted Therapy Date	☐ Palliative Care Date	☐ Hospice Date	☐ Other

Medical Provider Verification

- Physician must complete, verifying the applicant's cancer diagnosis and current treatments

Physician Name and Title (Print)

Phone Email

Phone and Email

Clinic or Hospital

Clinic or Hospital Address, City, ST

☐ **I confirm the patient is in my care, has breast cancer and/or has a history of breast cancer and is receiving active treatments as stated above.**

Physician Signature Date

Comments: