AFRICAN AMERICAN BREAST CANCER ALLIANCE, INC.
'Lil Help, a 'Lil Hope"
FINANCIAL ASSISTANCE PROGRAM APPLICATION

The African American Breast Cancer Alliance (AABCA) Breast Cancer Survivor Support Program (BCSS) created the **"Lil Help, A 'Lil Hope" Fund" (LHLH)** Grant Fund to provide Black/African Americans being treated for breast cancer some financial support during treatment.

The purpose of the LHLH Grant Fund is to help breast cancer patients and survivors experiencing financial stress due to active, critical, current and ongoing breast cancer treatments, resulting burdens and challenges. The fund offers limited One-Time grants of up to $500 for critical everyday living non-medical needs to adults, age 18+ treated with breast cancer mainly for those with limited resources.

PROGRAM INFORMATION

- Applicants must be recovering from breast cancer that is newly diagnosed, ongoing, and recurrent or that has metastasized for which they are now receiving treatment and/or hospitalized.
- Active and current treatment for Stages 0 – IV breast cancers, early stage to metastasis verified by patient's breast cancer oncologist/physician.
- Active cancer care treatments that cause a loss of employment, all or part of income, housing, insurance, medical supplies, transportation, utilities, severe treatment side effects, and other health issues that may impact care follow-up and outcomes.

QUALIFICATIONS

- Breast cancer diagnosis and treatments in the **last 2 ½ years**
- Currently undergoing active, current, or future surgery, chemotherapy, or radiation treatments considered critical cancer care for new, current, recurrent or metastasized cancers.
- Current breast cancer diagnosis, weekly, bi-weekly, monthly treatments and care verified by oncology care providers before approval of grant application that include the following:

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

- *Hormonal Therapy (such as Tamoxifen or Aromatase Inhibitors) is **not** considered active treatment.*

- Have a current annual household income of less than $70,000
- Needs financial help during current and upcoming cancer treatments.
- Limited to $500 total maximum per applicant, one-time per year.
- Financial assistance is **not** retroactive; bills must have a current or past due balance.
- Open to residents of the United States and District of Columbia

APPLICATION INSTRUCTIONS Checklist

- ☐ **Complete, print and sign the application pages 3 - 5 ONLY with applicant's E-mail address.**
- ☐ **Nurse Navigator/Oncology Nurse/Care Coordinator/Social Worker answers items 11 and 11A Pg. 5.**
- ☐ **Oncologist/Physician completes prints and signs the Medical Provider Form page 6.**
- ☐ **Copy of 1 to 4 allowable expenses for payment billed in patient's name and household address that are current or past due.**
  - **Housing – Mortgage or Rent**
  - **Utilities – Electricity, Gas, Telephone, Trash, Water**
  - **Insurance premium – Auto, Health, COBRA, Medical Deductible**
- ☐ **Applicant not allowed filling out page 6, which invalidates the application.**
- ☐ **A member of the Medical/Oncology Team may submit application on patient's behalf.**
- ☐ **Submit application package by E-mail directly to Grants@aabcainc.org, which is quickest.**

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The information requested is to complete the patient's application for financial assistance with hardships associated with treatment of a current cancer diagnosis. Applicant must be in ACTIVE, ongoing cancer care treatment now, to complete this application.

Our policy is to work with a patient's Care Coordinator, Nurse Navigator, or Social Worker. We do not work directly with applicants/patients unless necessary.

TERMS AND CONDITIONS:

- All information provided in this application and/or to AABCA, Inc. is confidential and used only for consideration of this application.
- Applications reviewed on a case-by-case, first come, first serve basis, and AABCA, Inc. will make the final decision based on patient status and financial hardship causes.
- Review of this application does **not** guarantee payment by AABCA, Inc.
- 15 days allowed patients to gather information and signatures for applying.
- Fraudulent, incomplete or unsigned applications are denied and not processed.
- Allow **60 days** for application review, notification and payment processing.
- Funding is limited to $500 maximum for one-time requests within 1 year.
- Payment Method by **Bill E-Pay**: Online payment (E-check) directly to Billing Company / Service provider, which is more secure and quicker. However, if vendor does **not** accept Bill E-Pay, a check is mailed directly to Billing Company.
- Payments are **not** made to meet company's invoice Due date.
- Checks are **not** payable to applicant. Past bills paid by applicant are not reimbursable. Credit card accounts are **not** allowed.
- AABCA terminates all financial assistance on the completion of chemotherapy, radiation, and/or qualifying treatments.
- Ineligible applicants are notified of denial and reason for ineligibility.
- Applicant authorizes AABCA agents, employees and/or representatives to obtain and discuss medical, treatment, therapy, financial and other information relating to the applicant's information and eligibility for this financial assistance program.
- Applicant freely submits this application and agrees to hold AABCA harmless for any losses that arise, either directly or indirectly, from the applicant's participation in the AABCA Financial Assistance Program.
- The LHLH Grant Program is dependent on available funds and AABCA reserves the right to modify and/or discontinue the program at any time and without prior notice.
- Questions about grant program or procedures? Please email Admin2@aabcainc.org.

KEEP PAGES 1 and 2 FOR YOUR INFORMATION

We hope the LHLH fund helps you and wish you the best in your recovery.

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Person completing this application?	☐ Patient	☐ Family/Friend	☐ Advocate	☐ Healthcare Professional
Print Name		Signature		Date

1. Applicant Information

First Name ______ MI ______ Last Name ______

Home Address ______ Apt ______

City ______ State ______ Zip Code ______

Phone(s) ______ Email ______

Birth date ______ ☐ Female ☐ Male ☐ Veteran Marital status ______

2. Breast Cancer Diagnosis Information – During the last 2 ½ years

Are you currently in treatment? ☐ Yes ☐ No Date of Diagnosis ______ Age at Diagnosis ______

Last Active Treatments	Surgery, Date	Chemotherapy, Date
	Radiation, Date	Immunotherapy, Date

Type of Breast Cancer	☐ Ductal CA In Situ (DCIS)	☐ Invasive Ductal	☐ Invasive Lobular	☐ Inflammatory
	☐ Paget's Disease	☐ Metaplastic	☐ Triple Negative	☐ Male/NOS

Current Stage

Stage: ☐ 0 ☐ I ☐ II ☐ III ☐ IV

☐ Recurrence ☐ Metastasis ☐ Recurrent Metastases ☐ Remission (Full or Partial)

3. Your Physician(s) responsible for your current, ongoing cancer patient care

Treatment	Name	Cancer Center/Hospital	Phone #
Oncology Chemotherapy			
Surgery			
Radiation			

4. Health Insurance Information

☐ None, Uninsured	☐ Private	☐ Medicaid	☐ COBRA	☐ Medigap Supplement
☐ Partner, Spouse Job	☐ VA Program	☐ Medicare	☐ FMLA	☐ Charity Care

5. Household and Income Information

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

Do other people live in your home or place of residence? ☐ No ☐ Yes # ______ ☐ Children ☐ Adults, ages 18+ ☐ Elderly

Income Sources ☐ Salary/Wages ☐ Retirement ☐ Social Security ☐ SSI ☐ SSDI ☐ Public Assistance ☐ Unemployment

Total Annual Household Income of all earners ☐ Under $20,000 ☐ Under $40,000 ☐ Under $60,000 ☐ Under $70,000

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6. Treatment Related Hardships

- ☐ 1 or more inpatient admissions in the past 90 days
- ☐ Frequent clinic visits, 2+ times/week
- ☐ Cancer treatments changed, delayed or missed
- ☐ Travel 2+ hours for clinic/hospital visits
- ☐ New cancer diagnosis
- ☐ Lost income
- ☐ Lost job
- ☐ Lost housing
- ☐ Work hours reduced
- ☐ Medical bills
- ☐ Supplies
- ☐ Medical complications
- ☐ Lost Health Insurance
- ☐ Food shortage
- ☐ Transportation
- ☐ Other health, life issues
- ☐ Lost PCA
- ☐ Child Care
- ☐ Elder Care

In need of other services: ☐ Emotional Healthcare ☐ Home Healthcare ☐ Financial Cancer Care ☐ Legal Cancer Care ☐ Lymphedema Care

7. Other information about your cancer experience(s) and effects on your care and life

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

- ☐ AABCA.org Website
- ☐ Support Group
- ☐ Doctor or Nurse
- ☐ Family/Friend
- ☐ Cancer Survivor
- ☐ Patient Navigator
- ☐ Social Worker
- ☐ Facebook/Social Media
- ☐ Another agency/organization (list):

9. Financial Assistance Needs during your cancer treatments

Include a copy of the bills, invoices or statements with patient's address with application

- **PAYMENTS: Made Directly to the Billing Company by Electronic Check (Bill E-Pay)**

Bill:	Name of Company	Billing Address	Account #	$ Amount
Housing Mortgage, Rent		See Mortgage, Lease, Statement	See Mortgage, Lease, Statement	$
Electric (Utilities)		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
Gas (Utilities)		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
Water (Utilities)		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
Telephone		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
Health /COBRA Insurance		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
Auto Insurance		See Bill, Invoice, Statement	See Bill, Invoice, Statement	$
TOTAL	**Limited to $500 maximum (1 - 4 bills)**			**$**

If Approved: allow 60 days for review, processing and payment

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10. Consent/Declaration of Applicant and Patient Release

- ☐ I am a breast cancer survivor recovering from surgery or undergoing active treatments.
- ☐ I currently have critical non-medical household expenses and need financial assistance during my current and/or future surgery, chemotherapy and/or radiation treatments.
- ☐ I affirm that I have read and understand 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.
- ☐ Treatment information, item 11A answered and signed by my healthcare team member.
- ☐ I will deliver the medical provider form to my Oncologist for verification and signature.
- ☐ I authorize the release of any medical information and documentation required by AABCA, Inc. for verifying this application by e-mail, USPS mail or telephone for verification.
- ☐ I understand that review of this application does not guarantee payment by AABCA, Inc.
- ☐ I understand that AABCA, Inc. will **not** disclose or publish any personal applicant information to any third party except as provided in this application for verification.
- ☐ I understand and agree to all Terms and Conditions and hold AABCA, Inc. harmless for any direct or indirect losses from participating in the program.
- ☐ *Optional:* I would like to receive information about AABCA's future events and news.

Applicant Signature ______________________ Date ____________

Note * Healthcare Professionals must complete items 11, 11A and Medical Provider Form

11. Cancer Center / Hospital Contact Information

Phone #

Hospital Name ______________________

Hospital Address ______________________

	Name	Email Address	*Phone #*
Oncology Nurse			
Nurse Navigator			
Social Worker			
Care Coordinator			
Radiation Oncology			

11. A) Patient/Nurse Navigator, Care Coordinator, Oncology Nurse, or Social Worker required verifying these statements and signing below:

	Date
If patient will have surgery for their breast cancer diagnosis, please provide date	
If patient is receiving chemotherapy treatments, please provide date of last treatment	
If the patient is receiving radiation therapy, please provide date of last treatment	

Name: ______________ Signature ______________ Date ______________

Print this page and sign

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MEDICAL PROVIDER FORM

*** Must be filled out by Oncology/Physician ***

Patient Information

Last Name	First Name	MI	Birthdate	Pt ID # (optional)

Date of Diagnosis:	Treatment Timeline	# of Months	Begin Date	End Date

Please complete and verify the oncology, treatment and patient status information for the applicant above. Return the Medical Provider form to the patient or to the African American Breast Cancer Alliance, (AABCA) by E-mail, Grants@aabcainc.org and include applicant's name in the subject line.

Breast Cancer Diagnosis, Type and Current Active Treatments

Type
- ☐ Ductal CA In Situ (DCIS) ☐ Invasive Ductal ☐ Invasive Lobular ☐ Inflammatory
- ☐ Paget's Disease ☐ Metaplastic ☐ Triple Negative ☐ Male/NOS

Subtype
- ☐ ER+/HER2- ☐ ER-/HER2+ ☐ TNBC ER-/PR-HER2- ☐ TNBC ER+PR+/HER2+

Current Stage
- ☐ 0 ☐ I ☐ II ☐ III ☐ IV ☐ Metastases
- ☐ Recurrence ☐ Recurrent Metastasis ☐ Remission (Full or Partial)

Active Treatments
- ☐ Chemotherapy Date(s) ________ ☐ Surgery Date(s) ________
- ☐ Lumpectomy ☐ Mastectomy ☐ Mastectomy with Reconstruction
- ☐ Radiation Date(s) ________ ☐ Targeted Therapy (IV) Date ________

Other Treatments
- ☐ Immunotherapy ☐ Palliative Care ☐ Other
- ☐ Hormone Therapy ☐ Hospice

Breast Cancer Physician Verification

Must be completed by Oncologist/Physician

☐ Physician may send a letter on official institution letterhead verifying the applicant's cancer diagnosis and current treatment plan. AABCA Inc. may contact the medical team to confirm information.

Physician Name, Degree, License # ________________________________

Phone # ________________ **Email** ________________

Hospital, Cancer Center Address, City, ST, Zip code ________________________________

☐ I confirm the patient is in my care, has breast cancer and/or has an ongoing history of breast cancer of 2 ½ years through present date and is currently receiving active treatments as stated above.

Physician's Signature ________________________ Date ____________

Comments: ________________________________

Print this page and sign