DOCUMENTS REQUIRED

The following documents will need to be submitted by applicant along with the attached application:

1. **Illness information sheet (included in application)**
2. **Breast cancer diagnosis information, including timing of plans for surgery**
3. **Tax returns for the most recent tax period**
4. **Explanation of benefits from health insurance**
5. **Letter of specific assistance requested, including expenses expected to be incurred, and any additional information relevant to the particular financial condition or personal situation that would assist the committee in fully understanding the needs of applicant.**

CANCER ASSOCIATION OF GREATER NEW ORLEANS
824 ELMWOOD PARK BLVD. SUITE 154
NEW ORLEANS, LA 70123

TELEPHONE: 733-5539, **WITHIN** Metro New Orleans
TOLL FREE: 1-800-624-2039, **OUTSIDE** Metro New Orleans
FAX Line: (504) 733-0252

PRINT OR TYPE LEGIBLY

PATIENT SERVICES ELIGIBILITY FORM

Breastoration Fund

Patient's Name _____ Date of Birth: _____

Address _____ Apartment _____

City _____, State _____ Zip _____

Social Security Number _____Telephone Number _____

Email address, if applicable _____

Insurance Company _____

Does Your Insurance Company Pay for Outpatient Medications(s)? Yes _____ No _____

If Yes, What Percentage Does the Insurance Company Pay? _____ percent is paid by the company.

Policy Number _____ Effective Date _____

Medicare A # _____ Effective Date _____

Medicare B # _____ Effective Date _____

Medicare D # _____ Effective Date _____

Medicaid Number _____ Effective Date _____

INCOME: Please list Family member's name, **ALL SOURCES** of income **AND** include **AMOUNTS OF EACH SOURCE OF INCOME and the most recent tax return for each person**.

	Family Member's Name	Amount of Income	Source of Income and/or Place of Employment
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

FAMILY INFORMATION: Please list **ALL** family members who are **LIVING WITH THE PATIENT** and include any information about any health problems of those family members, their relationship to the patient, and ages of family member(s).

	Family Member's Name, age, relationship to patient	Health Problem, if any
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

STATISTICAL INFORMATION: (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE _____ SEX _____ NATIONALITY _____

Please circle the correct choice below:

Do you currently use tobacco in any form? YES EX-TOBACCO USER NEVER USED TOBACCO

Do you have Diabetes? YES NO

INFORMATION ABOUT THE PATIENT'S ILLNESS: PLEASE PRINT!

1. PHYSICIAN'S NAME _____

   EMAIL _____

   SECTION/DEPARTMENT _____

   ADDRESS _____

   _____

   _____

   DEPARTMENT'S TELEPHONE NUMBER(S) _____

   DEPARTMENT'S FAX NUMBER(S) _____

2. Have you already undergone a mastectomy? If so, please state when the mastectomy took place and you underwent a single or bilateral mastectomy:

   _____
   _____
   _____
   _____
   _____
   _____

3. **Please submit all information related to anticipated reconstruction surgery** including but not limited to any explanation of benefits provided by your insurer(s), summary of insurance benefits, and/or an estimate of the cost of reconstruction. You may include related non-medical expenses (such as child care or commuting expenses, if applicable), but please include documentation:

   _____
   _____
   _____
   _____
   _____
   _____

_____
_____
_____
_____
_____

4. WHEN DO YOU EXPECT TO UNDERGO RECONSTRUCTION?

_____
_____
_____
_____
_____

5. Where will you have reconstruction? Please list Parish, Hospital, and name of provider.

_____
_____
_____
_____
_____

6. Please **submit copies of all medical bills related to the breast cancer treatment.**

7. Please attach a statement describing any financial hardship not listed above that may prevent you from seeking reconstruction. If there are expenses associated with that hardship, please quantify those expenses and provide documentation of those costs, if available.

8. NAME OF PERSON SUPPLYING INFORMATION _____

   RELATIONSHIP TO PATIENT _____

9. CONSENT TO RELEASE INFORMATION: I, _____ [Patient], acknowledge and agree that CAGNO may provide my name, address, the amount of any award that I may receive, and any other information CAGNO receives about me in connection with this application, to the Greater New Orleans Foundation, the United Way, the IRS, and any other organization or agency to which CAGNO has or may have a reporting obligation.

**By signing this form, I represent and warrant under penalty of law that the above statements are true and correct to the best of my knowledge. I understand and agree that all decisions made by the Cancer Association of Greater New Orleans are final. I understand that my application does not guarantee that I will receive any funds. The Cancer Association will not make decisions based on the physician or hospital where I choose to receive services, but reserves the right to give preference to applicants who reside in the New Orleans metropolitan area. I understand and agree that the Cancer Association reserves the right to make awards in any form the Cancer Association chooses, including but not limited to awards in the form of cash, reimbursements, and/or directed payments to creditors. I understand that I will provide additional documentation to the Cancer Association if and when requested.

_____ _____

PRINTED Name of Patient **SIGNATURE** of Patient

_____

Today's Date (***PLEASE*** **PRINT**!!!)

CANCER ASSOCIATION
824 Elmwood Park Boulevard
Suite 154
New Orleans, LA 70123-3342
(504) 733-5539, **WITHIN** Metro New Orleans
1-800-624-2039, **OUTSIDE** Metro New Orleans
FAX: (504) 733-0252

A UNITED WAY PARTNER

Illness Information Sheet

Date : _____

To : Paula Gros
Patient Services Director

RE : Statement of Need of Breast Reconstruction as a Result of the Diagnosis of Cancer and Mastectomy

Per the requirements of the Cancer Association, a United Way agency, this letter represents that I am the treating physician for _____(hereafter "Patient"), that Patient was diagnosed with BREAST CANCER in the **RIGHT / LEFT / BOTH [Circle One]** Breast(s) on _____ **[Date of Diagnosis], Stage 1 2 3 4 [Circle One]** with metastasis to _____. The Patient **UNDERWENT / WILL UNDERGO [Circle One]** a mastectomy in the **RIGHT / LEFT / BOTH [Circle One]** Breast(s) on _____ **[Date].** As the Patient's treating cancer physician, I certify that the Patient is in need reconstructive surgery of the **RIGHT/ LEFT/ BOTH [Circle One]** Breast(s) as a result of the mastectomy.

Scheduled date of breast reconstruction surgery: _____.

If you need or require any additional information regarding this patient, please do not hesitate to call _____ at (_____) _____.

Sincerely,

_____ _____
Signature of Physician **PRINTED** Name of Physician

Physician's Address _____

_____

_____

_____

Physician's Telephone (_____)_____