Information and Documents and Requirements

The following documents will need to be submitted by applicant along with the attached application: Please submit information related to anticipated reconstruction surgery.

1. **Breastoration does not pay for the cost of reconstruction**

2. **Letter of specific assistance requested (non-medical) 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.**

Examples:

Basic Monthly living expenses:
Lost wages during surgery and recovery
Rent/Mortgage
Utilities
Prescriptions
Non-food grocery items (cleaning, toiletries, etc.)
Food
Child Care
Insurance

3. **Illness information sheet (included in application)**
4. **Breast cancer diagnosis information, including timing of plans for surgery**
5. **Tax returns for the most recent tax period**
6. **Explanation/Summary of benefits from health insurance**

Cancer Association of Greater New Orleans

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

Patient Services Eligibility Form for the 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.	_____	_____	_____

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.	_____	_____

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: This may be filled out by your oncologist

All information in this section is required and must be completed

PHYSICIAN'S NAME PLEASE PRINT _____

SIGNATURE ** **of Physician (required)** _____

SECTION/DEPARTMENT_____

ADDRESS_____

_____

DEPARTMENT'S TELEPHONE NUMBER(S) _____**DEPARTMENT'S FAX** _____

CURRENT TREATMENT FACILITY: _____

1. **PATIENT WAS DIAGNOSED WITH Stage 0 1 2 3 4 Cancer of the RIGHT/LEFT/BOTH**

   ON ____/_____/_____ **WITH Mets to**_____

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. WHEN DO YOU EXPECT TO UNDERGO RECONSTRUCTION?

   _____
   _____
   _____
   _____
   _____

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

_____

_____

_____

_____

_____

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

6. Please attach a statement/paragraph 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. IF this is not enough room you may submit it on a separate piece of paper.

_____

_____

_____

_____

_____

_____

_____

_____

_____

7. 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 of Greater New Orleans

BREASTORATION

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

Breast Reconstruction Information Sheet

Date: _____

To: Paula Gros - Patient Services Director

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

Per the requirements of CAGNO/Breastoration, this letter represents that I am the breast reconstruction surgeon for _____ (hereafter "Patient").

Check one or all that apply

Mastectomy Information

☐ The Patient had or will have a Unilateral mastectomy on the **RIGHT / LEFT [Circle One]** breast on _____ **[Date].**

☐ The Patient had or will have a Bilateral mastectomy on _____ **[Date].**

Breast Reconstruction Information

☐ The Patient had or will have unilateral reconstruction on the **RIGHT / LEFT [Circle One]** breast on _____ **[Date].**

☐ The Patient had or will have bilateral reconstruction **[Circle One]** on _____ **[Date].**

☐ The Patient had or will have unilateral reconstruction on a single breast with a breast lift, breast reduction or breast augmentation of the unaffected breast on _____ **[Date].**

☐ The Patient had a single mastectomy in the past but will have a bilateral mastectomy and reconstruction on both breasts on _____ **[Date].**

CAGNO
Cancer Association of Greater New Orleans

BREASTORATION

Reconstruction Surgeon Verification

As the Surgeon, I certify that the patient is in need of reconstructive surgery of the **RIGHT/ LEFT/ BOTH [Circle One]** Breast(s) as a result of the mastectomy.

_____ _____

Signature of surgeon preforming the reconstruction

Printed Name of surgeon preforming the reconstruction

Address/Location of surgery _____

Surgeon Telephone (_____)_____

If you have any questions regarding this application, please call 504-733-5539 or email tammy@cagno.org

Sincerely,

Tammy L Swindle

Extra room for Letter of specific assistance requested (non-medical). This describes your unique situation and the financial hardship you are undergoing because of your diagnosis and reconstruction