Mail Completed form to: Judy Peck
41432 US Rt. 11
Antwerp, NY 13608
315-287-3752

APPLICANT FORM

Patient #_____

# Gouverneur Breast Cancer Fund

## Quality of Life Assistance Application

**Confidential - Please Print**

**Section 1: Patient Information**

**How Did you hear about the Gouverneur Breast Cancer Fund?**

Social Worker: ___ Oncology Navigator___ Clinic/Doctor___ Radio:___ Newspaper:___ TV:___ Friend:___

Family History of Breast Cancer (Please check all that apply): Self:___ Mother:___ Daughter:___ Sister:___ Other:___
Don't Know:___ Extended Family:___

Patient Name:_____ Date of Birth:_____ Gender: M / F
Address:_____
City/Town:_____State:_____ County:_____ Zip:_____
Email Address:_____
Home Phone:( ) _____ Work Phone:( ) _____ Mobile Phone:( ) _____
Is it okay to leave a message with someone: Y / N or on an answering machine/voicemail: Y / N

Patient Employer:_____
If patient is a minor, please list parent(s) or guardian(s) name(s):_____

Insurance Information

Do you, the patient have insurance? Y / N If Yes, Person's name it is under:_____

Insurance Co.:_____

Do you Have a secondary Insurance? Y/N

Medicaid:_____Medicare:_____Veteran:_____

Name Of Person Completing Form:_____ Relationship to Patient:_____
Address:_____ City/Town:_____State:_____Zip:_____
Home Phone ( )_____ Work Phone:( )_____
Emergency Contact Person:_____Relationship to Patient:_____
Home Phone ( )_____ Work Phone:( )_____Cell Phone:_____

**Section 2: Assistance Request**

Please Mark Box For Request

☐ Transportation for Treatment Amount Requested:$_____

☐ Cancer Related Medication, Deductibles and Dr. Expenses: Amount Requested:$_____

☐ Dependent Care during Patient treatment Amount Requested:$_____

☐ Other:(Household Expenses): Amount Requested:$_____

**Receipts are required for reimbursement. First time Applicant for transportation does not need receipts**

**Section 3: Treating Physician Information:**

Physician's Name:_____
Address:_____City/Town:_____State:_____Zip:_____
Office Phone No.:_____ Office Fax no.:_____

Section 3: Patient Release Of Information

I HAVE CONTACTED THE GOUVERNEUR BREAST CANCER FUND FOR ASSISTANCE AND HEREBY AUTHORIZE MY DOCTOR TO RELEASE INFORMATION REGARDING MY ( OR MY CHILD'S) ILLNESS AND ITS TREATMENT TO THE GBCF ADMINISTRATOR(S). I AM SUBMITTING THIS APPLICATION FOR EMERGENCY ASSISTANCE DUE TO THE FINANCIAL BURDEN INCURRED AS A RESULT OF BREAST CANCER.

Date:_____ Applicant's Signature:_____