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:____

Mail Completed form to: Judy Peck

PHYSICIAN FORM

Paitent #____________

41432 US Rt. 11
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Gouverneur Breast Cancer Fund

Quality of Life Assistance Application - Part II

Confidential - To Be Completed By Treating Physian - Please Print

General Patient Information:

Patient Name:____ Date Of Dx:__________________

DX:____

Dx know to Patient? Yes:____ No:____ Dx know to family? Yes:____ No:____

Type of treatment:

____

____

____

____

Financial Assistance with Transportation:

Treatment location:

____

____

Is Patient Ambulatory? Yes:____ No:____

Financial Assistance with Medication

Please list class of medication and specific drugs related to Patients Breast Cancer

Class Of Medication:	Specific Drug:
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

Please list any Comments pertaining this patients situation you feel the GBCF needs to be aware of:

____

____

____

Physician's Name:____

Physician's Signature:____ Date:______________________