BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

Dear Applicant:

The Breast Cancer Assistance Program provides assistance to women facing financial challenges. This program provides ***free mammograms*** and financial assistance for: ***medical related lodging, co-pay, and office visits.***

- During Breast Cancer treatment
- Non-Breast Cancer survivor for free mammogram

Attached are the Application and Physician Verification Form. ***Each form must be completed and submitted with the REQUIRED SUPPORTING DOCUMENTS (i.e., medical bills).*** Upon completion and submission of the forms, the application process takes a minimum of 7 to 10 business days.

If your application is approved you are asked to do the following:

- **Submit a statement of testimony** to **infonet@sistersnetworkinc.org** at times with approval which may be posted on our website.

- ***Contact your local Sisters Network Chapter at time of approval and become an "active or associate" member**
  ***If a chapter is located in your area.**

If the above requests are not met, you will be ineligible for funding.

It is our goal to assist you financially, but we would also like for you to connect with one of our chapters. Sisters Network® Inc. (SNI) is a leading voice and only national African American breast cancer survivorship organization in the United States. Our purpose is to save lives and provide a broader scope of knowledge that addresses the breast cancer survivorship crisis affecting African American women around the country.

Wellness,
Sisters Network® Inc. National Headquarters

INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED!
REIMBURSEMENTS ARE NOT CONSIDERED

PLEASE EMAIL APPLICATION & SUPPORTING DOCUMENTATION TO:
orlandosistersnetwork@gmail.com
Or Mail To:
Sisters Network Orlando • P.O. Box 618613 • Orlando, Florida 32861

Revised 1/2012

Sisters NETWORK® INC.
A National African American Breast Cancer Survivorship Organization

Office Use Only:
Verification Date: _____ Scan Date: _____

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IF APPROVED, FINANCIAL ASSISTANCE PAYMENTS ARE MADE DIRECTLY TO THE PROVIDER. SUBMISSION OF THIS APPLICATION DOES NOT IMPLY OR GUARANTEE APPROVAL OF FINANCIAL ASSISTANCE

PERSONAL INFORMATION (PRINT CLEARLY)		
Are you a member of a ***Sisters Network Affiliate Chapter***? ☐ Yes ☐ No		If **YES**, what chapter?
First Name:		Last Name:
Date of birth (M/D/Y):	Phone:	Email:
Current address:		
City:	State:	ZIP Code:

ASSISTANCE REQUESTED (CIRCLE ONE)		
Have you received BCAP in the last 12 months? ☐ Yes ☐ No		
Office Visit Copay	Medical Related Lodging	Treatment Copay
Mammogram	Other (please describe)	

TREATMENT INFORMATION	
Stage of Breast Cancer:	Age at Diagnosis:
Treatment:	
Are you currently in treatment? ☐ Yes ☐ No	If **YES**, Treatment dates: Start:_____ Finish:_____
If **YES**, type of treatment:	

FINANCIAL STATUS		
Are you currently employed? ☐ Yes ☐ No	If **NO**, state reason:	
List sources of income:		
Amount of Request: $	Head of Household ☐ Yes ☐ No	Number in Household:
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K		
Explain circumstances creating financial need at this time:		

HOW DID YOU HEAR ABOUT SISTERS NETWORK® INC.?		
Referred by:		
Did referring Organization give you any assistance?: ☐ Yes ☐ No		
If **yes**, type of assistance:	Amount of assistance: $	
Contact Name	Contact Email	Contact Phone

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PHYSICIAN VERIFICATION FORM
BREAST CANCER ASSISTANCE PROGRAM (BCAP)

Dear Physician:

Your patient has applied for financial assistance from our organization. In order to complete the enrollment process we must verify the following information with you as the ***prescribing and/or treating physician***. You may either return this form to your patient or fax it to the number listed above. Please contact Sisters Network® Inc. if you have questions.

PATIENT INFORMATION (PRINT CLEARLY)		
		Today's Date:
First Name:		Last Name:
Date of birth:	Phone:	Email:
Current address:		
City:	State:	ZIP Code:
TREATMENT INFORMATION		
☐ Check here if applicant is requesting assistance for a mammogram (please send referral and/or prescription)		
Stage of Breast Cancer:	Treatment:	
Currently in treatment? ☐ Yes ☐ No	Treatment dates: Start:_____ Finish: _____	
If **YES**, type of treatment:		
PHYSICIAN CONTACT		
Physician Name:		
Organization/Hospital:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:
Office Contact Name:	Position:	Phone (if different):
☐ I certify that the patient named is currently a patient and has been diagnosed with breast cancer and is currently under my care for treatment.		
☐ I certify that the above named is currently a patient and has been given a referral and/or a prescription for a mammogram		
Health Care Professional/Physician Signature: _____ Date: _____		

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