Hopkins BREAST CANCER INC.
The Helping Hand in the Community

APPLICATION FOR ASSISTANCE
A 501C (3) Non-profit organization

DATE: _____

Name: _____

Date of Birth: _____ Race: _____ Ethnic Origin: _____ Gender: _____

Home Address: _____
(street)

_____ _____ _____
(city) (State) (Zip)

Work Address: _____
(street)

_____ _____ _____
(city) (State) (Zip)

Phone Home ( ) _____ Work ( ) _____

Contact Person: _____

Phone: ( ) _____

Email address: _____

Number of Persons in Household: _____ **Total income in Household**: _____
(per month)

Please provide a copy of the bill or bills that you are requesting assistance for:

Type of Assistance Requested: Check all that apply

- ☐ Diagnosis
- ☐ Transportation
- ☐ Medication
- ☐ Rehabilitation
- ☐ Specific Request: Amount $_____
- ☐ Hospital Bill/Treatment/Doctor
- ☐ Medical Supplies
- ☐ Other (please explain)
- ☐ Insurance Premium

P.O. Box 7132 Silver Spring, MD
20907 (301) 755-6253
www.hopkinsbcinc.org

Purpose: _____

_____

_____

_____

_

Medical Coverage: ***Check all that apply***

☐ I have private health insurance (Name of Insurer & Contact # _____
☐ I have Medicare
☐ I have Medicaid in: ☐ D.C. ☐ VA ☐ MD or other state ☐ (explain)_____

☐ I am uninsured: If not receiving Medicaid, why not _____

☐ **Other resources**: List any other sources from which you have tried to received breast cancer assistance: _____
_____
_____

Financial Status

Monthly Household Income

	Patient	Spouse/Other
Salary (before deductions)	_____	_____
Pension	_____	_____
Social Security	_____	_____
Retirement	_____	_____
Social Security Disability	_____	_____
Interest $ Dividends	_____	_____
Other	_____	_____
Total	_____	_____

To the best of my knowledge the information provided is accurate. Furthermore, I understand that completion of this application does not automatically guarantee granting of funds. All information is strictly confidential and is for Hopkins Breast Cancer Inc. use only. Hopkins Breast Cancer Inc. may discuss this information internally through verbal and electronic means to assess your application.

Signature: _____

Print Name: _____

If you have any questions, please contact the Hopkins Breast Cancer Inc. office at (301) 585-8812. Upon completion, please mail the application to:

Hopkins Breast Cancer Inc.
P.O. Box 7132
Silver Spring, MD 20907.

A board-member of Hopkins Breast Cancer Inc will contact you as soon as possible.

AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

I, the undersigned, hereby request and give permission to:

_____

(Name and contact information of health care provider) to release all medical information from the record of:

_____ _____ _____--_____--_____

Name of Patient **Date of Birth** **Social Security Number**

Information to be released:

All records of named patient's treatment including, but not limited to: correspondence; progress notes; nursing notes; name, address and phone number of next of kin or legal guardian; rehabilitation services assessment; minutes of interdisciplinary team meetings; individualized treatment plans; records of all medical diagnoses, diagnostic tests, and treatments.

The purpose of this disclosure is for Financial and social support

1. I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records.
2. I understand that the health care entity may not condition treatment or payment on my willingness to sign this authorization.
3. I also understand that I have the right to revoke this authorization at any time, but that my revocation is not effective until delivered in writing to the person who is in possession of my health records and is not effective as to health records already disclosed under this authorization.
4. A copy of this authorization and a notation concerning the persons or agencies to which disclosure was made shall be included with my original health records.
5. I understand that health information disclosed under this authorization might be re-disclosed by a recipient and may, as a result of such disclosure, no longer be protected to the same extent as such health information was protected by law while solely in the possession of the health care entity.

_____ _____ _____

Signature of Patient Print Name Date

_____ _____ _____

Signature of Legal Guardian/ Print Name/Relationship to Date
Authorized Person Patient