



Office Use Only:

Date Rec'd: _____ Scan Date: _____

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

Dear Applicant:

The Breast Cancer Assistance Program (BCAP) provides services to women facing financial challenges. The BCAP program provides financial assistance for but not limited to *medical related lodging, co-pay, office visits and prosthesis*. This program also provides **FREE mammograms** for those who qualify.

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 completed application will take up to 30 business days to process.

BCAP is designed to assist breast cancer survivors during treatment – RADIATION or CHEMOTHERAPY.

It is our goal to assist you financially *during your journey*. Sisters Network® Inc. 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.

Please submit forms to info@sistersnetworkchicagochapter.org or mail them to:

Sisters Network, Inc. – Chicago Chapter

Attn: Mrs. Annie Jones

10727 S. Eberhart Ave.

Chicago, IL 60628

As a Survivor, we would like to invite you to connect with Sisters Network Chicago.

Wellness,

Sisters Network® Inc. – Chicago



Chicago Chapter

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

All information provided on this form will be kept CONFIDENTIAL.

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

PERSONAL INFORMATION (PRINT CLEARLY)

Today's Date

Are you a member of a **Sisters Network Affiliate Chapter**? Yes No

If **YES**, what chapter?

First Name

Last Name:

Date of Birth (MM/DD/YYYY)

Phone

Email

Current Address

City

State

Zip Code

Insurance Yes No

If Yes: Private/Commercial County/State Medicaid/Medicare

Have you received BCAP in the last 12 months? Yes No

ASSISTANCE REQUESTED (CIRCLE ONE)

Office Visit Co-Pay

Medical Related Lodging

Treatment Co-Pay

Mammogram

Other (please describe)

TREATMENT INFORMATION

Age at Diagnosis

Are you currently in treatment? Yes No

If **YES**, treatment dates – Start: _____ Approximate Finish: _____

If **YES**, type of treatment:

FINANCIAL STATUS

Are you currently employed? Yes No

If **NO**, state reason

List sources of income

Amount Requested \$

Head of Household? Yes No

Number in Household

Annual Household Income

Explain circumstances creating current financial need

HOW DID YOU HEAR ABOUT SISTERS NETWORK® INC.? (REQUIRED INFORMATION)

Referred by

Did referring organization give you any assistance? Yes No

Contact Name

Contact Email

Contact Phone



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*. Please contact Sisters Network Inc. Chicago at (773) 353-8854 or info@sistersnetworkchicagochapter.org if you have questions.

PATIENT INFORMATION (PRINT CLEARLY)		
Today's Date		
First Name		Last Name:
Date of Birth (MM/DD/YYYY)	Phone	Email
Current Address		
City	State	Zip Code
TREATMENT INFORMATION		
<input type="checkbox"/> Check here if applicant is requesting assistance for a mammogram (please send referral and/or prescription)		
Type of Breast Cancer		
Stage of Breast Cancer	Treatment	
Currently in treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, treatment dates – Start: _____ Approximate Finish: _____	
PHYSICIAN CONTACT		
First Name		Last Name:
Organization/Hospital		
Current Address		
City	State	Zip Code
Phone	Fax	Email
Office Contact Name	Position	Phone (if different):
<input type="checkbox"/> 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. <input type="checkbox"/> 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: _____		