***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 ajones11044@aol.com 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

**BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION**

***All information provided on this form will be kept CONFIDENTIAL.***

|  |
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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.****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 |

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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.***Please contact Sisters Network Inc. Chicago at (773) 353-8854 or ajones11044@aol.com 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** |
|  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?**  Yes  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): |
|  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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