Chicago Chapter

***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

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 |

Chicago Chapter

# 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:** _____