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
**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:

Rev. 12/2019
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)

<table>
<thead>
<tr>
<th>Today’s Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First Name</td>
<td>Last Name:</td>
</tr>
<tr>
<td>Date of Birth (MM/DD/YYYY)</td>
<td>Phone</td>
</tr>
<tr>
<td>Current Address</td>
<td>Email</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
</tbody>
</table>

### Treatment Information

- Check here if applicant is requesting assistance for a mammogram (please send referral and/or prescription)

<table>
<thead>
<tr>
<th>Type of Breast Cancer</th>
<th>Stage of Breast Cancer</th>
<th>Treatment</th>
</tr>
</thead>
</table>

- Currently in treatment? □ Yes □ No  
  - If YES, treatment dates – Start: _______________  Approximate Finish: _______________

### Physician Contact

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization/Hospital</td>
<td></td>
</tr>
<tr>
<td>Current Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>Phone</td>
<td>Fax</td>
</tr>
<tr>
<td>Office Contact Name</td>
<td>Position</td>
</tr>
</tbody>
</table>

- □ 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: ___________________________