A BREAST CANCER LIFELINE
Gateway to hope

APPLICATION CHECKLIST

Name of Applicant: _____ Phone Number: _____

All of the following items must be included in your application package and any missing documents or information may result in delayed processing. A Gateway to Hope Navigator will contact you within 7-10 days to determine program eligibility, request additional documentation (if applicable), and provide additional information about the program. Although GTH strives to provide assistance in a timely manner, we are not an emergency financial assistance program.

Check	Document or Description
☐	Completed application with all forms ○ Financial Worksheet (p. 3) ○ Applicant Attestation (p. 4) ○ Authorization of Disclosure of Protected Health Information (p. 5)
☐	A signed letter, health records or verbal confirmation from a medical professional confirming diagnosis and treatment plan
☐	First 3 pages of your tax returns from the previous year[1]
☐	Copies of billing statements for basic living expenses and/or health insurance premiums (with breakdown for multiple policy members) you wish to be considered for payment.

1. If last year's return is not available, submit the return from the previous year. If married and filed separately, submit all returns. If tax return is not filed, submit all W-2s and 1099 forms from the previous year. SSI award letter also accepted if other documentation not available. ***If tax return not filed, please attest below***.

☐ Check if applicable: I attest that I have not filed taxes for the last two years.

☐ Check here if you would be willing to share your story with others, if asked in the future.

APPLICANT'S SIGNATURE (type name to sign): _____ DATE: _____

MAIL, FAX, or EMAIL YOUR COMPLETED APPLICATION and all required documents to:

3114 Sutton Boulevard
Maplewood, MO 63143
Or Fax: 314-432-3303
Or Email: info@gthstl.org

*Individuals residing in the southwest region of Missouri covered by the Breast Cancer Foundation of the Ozarks (BCFO) will be directed to BCFO for assistance with basic living expenses and will only be eligible for insurance premiums assistance through Gateway to Hope. Please visit http://www.bcfo.org/ for more information.

GATEWAY TO HOPE PROGRAM APPLICATION

NAME: _____

DATE OF BIRTH: _____

MARITAL STATUS: _____

RACE/ETHNICITY: _____

GENDER:

GENDER PRONOUNS:

she/her ◯ he/him ◯ they/them ◯ other: _____

STREET ADDRESS: _____

CITY: _____

EMERGENCY CONTACT NAME & NUMBER:

_____

DATE: _____

COUNTY: _____

STATE: _____

PHONE: _____

EMAIL: _____

OCCUPATION: _____

LANGUAGE: _____

HEALTH INSURANCE PROVIDER: _____

 # PERSONS COVERED: _____

HAVE YOU DELAYED A MAMMOGRAM IN THE PAST?
(THIS DOES NOT AFFECT PROGRAM ELIGIBILITY.)

_____

TREATMENT INFORMATION

DIAGNOSIS: _____ **STAGE:** **ER-** ☐ **ER+** ☐ **PR-** ☐ **PR+** ☐ **HER2+** ☐ **HER2-** ☐

BIOPSY DATE: _____ BREAST: LEFT ◯ RIGHT ◯ BOTH ◯ FACILITY: _____

SURGERY: PHYSICIAN: _____ FACILITY: _____

PROCEDURE: LUMPECTOMY ◯ MASTECTOMY ◯ LEFT ◯ RIGHT ◯ BILATERAL ◯ DATE: _____

ONCOLOGY (CHEMOTHERAPY): PHYSICIAN: _____ FACILITY: _____

TREATMENT PLAN: _____

NEO-ADJUVANT (BEFORE SURGERY) START DATE: _____ DATE COMPLETED: _____

ADJUVANT (AFTER SURGERY) START DATE: _____ DATE COMPLETED: _____

RADIATION ONCOLOGY: PHYSICIAN: _____ FACILITY: _____

OF TREATMENTS PLANNED: _____ START DATE: _____ DATE COMPLETED: _____

REFERRAL SOURCE: NAME: _____ TITLE (IF APPLICABLE): _____

FACILITY (IF APPLICABLE): _____

SOCIAL WORKER/CASE WORKER/NURSE NAVIGATOR (OPTIONAL): NAME: _____

PHONE: _____ FACILITY: _____

APPLICANT'S SIGNATURE: _____ **DATE:** _____

Financial Worksheet

Complete financial information is required on all household members. **Number in Household** _____

Household Assets and Income		Monthly Household Expenses	
Checking Account.	$_____	❑ Rent ❑ Mortgage	$_____
Savings Account	$_____	Phone(s)	$_____
Retirement Assets (e.g. 401k, IRA)	$_____	Utilities	$_____
Stocks & Bonds	$_____	***Transportation***	
Monthly Household Income	$_____	Auto Payment(s)	$_____
		Auto Insurance	$_____
		Medical Expenses	
		Monthly Health Insurance Premium	$_____
		Misc. (Specify)	$_____
		Misc. (Specify)	$_____

Not all bills may be eligible for assistance. Eligible bills include health insurance premiums, medical bills, rent/mortgage, childcare, basic utilities (electric, gas, water, sewer, waste management), telephone, internet, car insurance, car payment, and car repair. **Bill must be in applicant's or spouse's name. Applicants in BCFO territory (southwest MO) only eligible for health insurance premium assistance.*

To qualify for assistance, applicants must have a breast cancer diagnosis, be actively undergoing treatment for breast cancer, and have a household at or below 450% of the federal poverty line. Applicants can calculate income eligibility by visiting: https://www.needymeds.org/FPL_Calculator.

Applicant Attestation

In consideration for acceptance into the Gateway to Hope Program, I agree and certify as follows:

1. I attest that the information provided in this application is complete and accurate to the best of my knowledge.
2. I understand that while every effort will be made to provide assistance, the Program is limited to the availability of funds and I may not receive assistance even if I satisfy the eligibility requirements and the other terms and conditions in the Program Guidelines.
3. I understand the Program Guidelines and eligibility criteria could be modified at any time and the Program could be discontinued at any time.
4. I understand that GTH has the right to audit my eligibility and the accuracy of any documents or information I provide and to request that I provide any additional information. I understand that if I apply to receive assistance beyond the original grant term, I will be required to submit updated information to GTH.
5. I understand that GTH will have the right to terminate any assistance granted if GTH becomes aware that any information provided in this application is not accurate, if I do not provide any information requested by GTH or if I do not meet the eligibility requirements and other terms and conditions set forth in the Program Guidelines.
6. I will promptly notify GTH of any changes to the information I have provided to GTH, including financial situation, health insurance status, or medical condition.
7. I understand that I am not required to use any particular health care provider as a condition of receiving assistance under the Program and I am free to change my health care providers at any time.
8. I acknowledge that GTH may disclose certain information from my application to my health insurance carrier, breast cancer caregivers, pharmacists, or other parties to fulfill my grant request.
9. I understand that from time to time, GTH aggregates data from many patients to create aggregated (summary) patient data which GTH may share with third parties, including researchers, partners, foundations, policy makers and other funding sources to help us apply for funding, prepare reports, advocate on behalf of patients, or perform other health related research.
10. I attest that I am not receiving financial assistance for the expenses for which I am seeking assistance from GTH. If applicable, in the event I become qualified for Medicaid coverage and in connection therewith, or otherwise, become entitled to a refund of insurance premiums, I agree that GTH shall be entitled to receive such refunds and I will transfer any such refunds I receive to GTH immediately.
11. If applicable, I understand that I must submit my health insurance reimbursement as soon as possible after payment and GTH will not pay claims received more than 120 days after payment date.
12. I understand that GTH is not an emergency fund and no payments are made automatically.
13. I understand that in no event shall GTH be liable in any way for damages alleged to result from errors or delays in the processing of Program applications or the issuance of payments as part of the Program, my choice of health care provider or the success or failure of any therapy or treatment I obtain using funds from the Program.

By signing below, I attest that I have read, fully understand and agree to the Applicant attestation set forth above.

_____

Applicant's Name (Please Print)

_____

Applicant's Signature Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

Patient's Name: _____ **Patient's Date of Birth:** _____

I hereby request that my health care provider identified below disclose the PHI described below to Gateway to Hope in connection with my application for assistance from Gateway to Hope.

Name of Health Care Provider: _____

PHI To Be Disclosed: breast cancer related health information_____

_____

Acknowledgment: If my medical record contains information about drug/alcohol abuse, mental health treatment, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I agree to its release. ***Check if you do not agree to release of sensitive information described herein:*** ☐ **Do Not Agree**

Date(s) of Service of PHI To Be Disclosed: All dates of services, unless otherwise specified below:

_____

Revocation Right: I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the above named healthcare provider at the address stated above and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Expiration: This Authorization will expire 3 years from the date of my signature below, unless otherwise specified herein:_____

Re-Disclosure: I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.

Signature: I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization. **By signing this document, I hereby authorize the above named provider to disclose my protected health information as specified in this document.**

_____ _____

Signature of Patient or Personal Representative **Date**

If this Authorization is signed by the patient's personal representative, indicate such representative's authority

to act on behalf of the patient: _____