BREATHE, INC. APPLICATION INSTRUCTIONS

APPLICANT NAME: _____ DATE: _____

ALL 5 PAGES MUST BE COMPLETED AND INCLUDED UPON SUBMISSION TO BE CONSIDERED FOR A GRANT.
YOU MUST BE IN ACTIVE TREATMENT FOR A CANCER DIAGNOSIS TO BE CONSIDERED.

1._____**COPY OF CURRENT DRIVER'S LICENSE OR STATE ID**
For proof of residency

2. _____ **COMPLETE CLIENT NEEDS ASSESSMENT**

3. _____ **AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

4. _____ **DIAGNOSIS VERIFICATION FORM**
To be completed by your oncologist

5. _____ **REQUEST FOR ASSISTANCE**

6. _____ **APPLICATION SIGNED BY APPLICANT AND ONCOLOGIST (MD,NP,PA)**

7. _____ **ALL 5 PAGES COMPLETED WITH COPIES OF BILLS AND ID**

Mail to:
Breathe, Inc PO Box 37 Lake Geneva, WI 53147
For any questions, please email Michelle:michelle@breatheinc.org
Shannon: shannon@breatheinc.org

CLIENT NEEDS ASSESSMENT

Applicant Name: _____DOB: _____ Age: _____

Phone:(___)_____ Address: _____

County: _____ City: _____Zip Code: _____

Number of Household Members: ____

Age and Relationship:_____

Oncologist: _____ Phone: (____) _____

Clinic/Hospital: _____

Cancer Diagnosis: _____

Please provide the name and phone number of someone we can contact on your behalf, if we are not able to reach you.

Contact Name: _____ Phone: (____) _____

BREATHE, Inc. must have a proof of residency, that includes your name on the bill, attached to this application. (Copy of Driver's License, phone bill, electric bill, mortgage/rent statement).

I verify that I am currently under treatment for a cancer diagnosis in the United States and am requesting financial assistance through BREATHE Inc.

(Applicant's Signature)_____ Date: _____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____
Name of Patient/Previous Names Birth Date/Medical Record Number

_____ _____
Street Address City, State, Zip Code

AUTHORIZES TO DISCLOSE TO:
Breathe Inc
PO BOX 37
Lake Geneva, WI 53147

AUTHORIZES DISCLOSURE BY:
_____
Name of Health Care Provider
Address_____
City,State_____
ZipCode_____

INFORMATION TO BE DISCLOSED:
Verification of current diagnosis related to cancer or treatment related to cancer

PURPOSE FOR DISCLOSURE:
To validate diagnosis to qualify for services through Breath Inc.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:
Right to inspect or receive a copy of the Health Information to be used or disclosed-I understand that I have the right to inspect or receive a copy of health information I have authorized to be used or disclosed by this authorization form. Right to receive a copy of this authorization-I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. Right to refuse to sign this authorization-I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. The consequence of not signing the authorization would be that information will not be disclosed. Right to withdraw this authorization-I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw this authorization or to receive a copy of my withdrawal, I may contact the facility disclosing information. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. The facility will not condition treatment on the completion of this authorization. I understand that once my health information leaves the control of the facility, it may be further disclosed by the receiving party. I agree that I will not hold the facility liable for re-disclosures of the health information I have authorized that are made by the recipient named in this Authorization.

EXPIRATION DATE: The authorization is good for 90 days from the date signed. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF PATIENT/LEGAL REP: _____DATE:_____

(If signed by other than patient, state relationship and authority to do so) _____

Breathe, Inc. Diagnosis Verification Form

ONCOLOGIST TO COMPLETE

I am verifying that: _____

(patient's name/DOB)

has a current diagnosis of cancer and is currently under my care.

Cancer diagnosis with staging:_____

Current treatment applicant is receiving

- ☐ Chemotherapy
- ☐ IV
- ☐ Oral-Name of chemotherapy_____
- ☐ Radiation
- ☐ Surgery- Date and suggested surgical recovery period

Provider Signature(MD,NP,PA):_____Date:_____

Oncology Provider Printed Name:_____

Hospital/Clinic Name: _____

Direct contact phone number for provider office: (_____) _____

****In order to be considered for a financial grant applicants MUST be in active treatment for a cancer diagnosis. Active treatment does NOT include surveillance, or hormone therapy. Oral chemotherapy will be reviewed on a case by case basis.****

ASSISTANCE REQUESTED

Applicant Name: _____ DOB: _____

Breathe Inc. will make check(s) out directly to the company you are seeking assistance for. The check(s) will be mailed to you so you can add your account number and forward to the company.

**Be sure to continue to pay your bills as applications are reviewed monthly with check(s) being mailed out at the end of each month.

**All checks must clear the bank within 60 days. Any outstanding checks beyond the 60 days will be canceled and applicants must reapply for assistance.

I am requesting assistance with the following bills:

Rent/Mortgage **Phone**

Company Name: _____ _____

• copy of statement attached

Utilities: Water/Sewer **Electric/Gas**

Company Name: _____ _____

• copy of statement attached

Insurance: **Car** **Health Premium**

Company Name:_____ _____

• copy of statement attached

Reason for application, include any special circumstances that Breathe, Inc. shouldconsider

_____

_____

_____

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