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/FINANCIAL INFORMATION FORM** (page 2)

3. _____ **SIGN RELEASE OF INFORMATION STATEMENT** (page 3)

4. _____ **ONCOLOGIST TO COMPLETE AND *SIGN* DIAGNOSIS VERIFICATION FORM** (page 4)

5. _____ **STATEMENT OF NEED COMPLETED AND SIGNED** (page 5)

6. _____ **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: Shannon@breatheinc.org

**********************FOR INTERNAL USE ONLY**********************
Application #_____
Status of Assistance Requested: ☐Approved ☐ Denied
Date Approved:_____ Amount Approved:_____
Check #(s)_____
Vendor(s) & Amount of Distribution_____

Financial Assistance Application for Support

CLIENT INFORMATION Today's Date:_____

Name:_____ Date of Birth:_____

Street Address:_____

City:_____ County:_____ Zip Code:_____

Phone:_____ E-Mail Address:_____

FINANCIAL INFORMATION

Employment Status: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student

Insurance Status: ☐Private Insurance ☐Marketplace ☐Medicare ☐Medicaid ☐VA Benefits ☐Uninsured

Number of People Living in Household:_____

Names/Ages of Household residents:_____

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: (____) _____

This section is optional. The information is collected for statistical and reporting purposes only and helps Breathe, Inc. maintain funding to continue offering services. Your responses will not affect your eligibility for services

Race: ☐Asian ☐Black ☐Native American ☐Latinx ☐White ☐ Other

Gender: ☐Male ☐Female ☐Transgender ☐Non-Binary ☐Other

Since your diagnosis, how would you rate the financial burden or stress you have experienced?

▢ **No financial burden**

Little to no change in your finances; costs were minimal or fully covered.

▢ **Slight increase in financial burden**

Some added expenses (copays, travel, time off work), but still manageable without major lifestyle changes.

▢ **Significant financial burden**

Noticeable strain: medical bills, reduced income, debt, using savings, difficulty covering regular expenses.

▢ **Critical Financial decline**

Major hardship: loss of income, inability to meet basic needs, reliance on assistance

REQUEST FOR FINANCIAL ASSISTANCE (attach corresponding bill if applicable)

Assistance is requested in relation to: *(check your most urgent needs)*

☐Gas/Transportation☐Groceries/Meals ☐Electric/Gas ☐Rent/Mortgage ☐Water/Sewer ☐ Phone ☐ Internet ☐Car Insurance ☐Car Payment ☐Health Insurance Premiums
☐Other: _____

Please note: We do NOT provide financial assistance for medical bills, treatment expenses, co-pays or deductibles

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.

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.

RELEASE OF INFORMATION: By signing below, I authorize Breathe, Inc. to obtain and discuss information related to the application with my physician and/or other treatment providers for the sole purpose of verifying my eligibility for financial assistance. All information related to this application will be kept strictly confidential and will not be shared with other parties.

Client or Guardian Signature:_____ Date:_____

DIAGNOSIS VERIFICATION: This section to be completed by a health professional at your treatment facility and signed by your provider (MD, NP, PA)

Patient's Name: _____

Date of Diagnosis:_____ Primary Cancer:_____ Current Stage:_____

Is the patient above *currently* under the care at your facility for cancer treatment?☐Yes☐ No
(Breathe, Inc. may require documentation of a diagnostic or monitoring test proving evidence of disease within the past 6 months).

Current Treatment Applicant is Receiving:

☐Surgery ☐IV Chemotherapy ☐Oral Chemotherapy ☐Radiation☐Immunotherapy
☐Hospice/Palliative Care

Frequency of Treatment:☐Daily ☐Weekly ☐Bi-Weekly ☐Monthly ☐Other

Provider Signature(MD,NP,PA):_____ **Date:**_____

Oncology Provider Printed Name:_____

Hospital/Clinic Name: _____

Street Address:_____ City:_____ Zip:_____

Name of Person Completing this Form:_____

Relationship to Patient:☐Physician☐Nurse☐Social Worker☐Other_____

Phone:_____ Email Address:_____

STATEMENT OF NEED

This section must be completed to be eligible for support
Remember to attach any bills you are requesting assistance for

Please use this space (or attach a separate sheet) to share the circumstances that have led you to seek assistance from Breathe, Inc. If your request is time-sensitive, please include any relevant deadlines. As Breathe, Inc. receives more applications for support than we can fund, we encourage you to share any details about your unique situation that may help us better understand your needs during the review process.

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SIGNATURE:

I attest that all information provided in this application is true and complete to the best of my knowledge. I understand that submission of this application does not guarantee a financial grant. I further understand that Breathe, Inc. will not make monetary payments directly to individuals. If financial assistance is awarded, funds will go directly to the service provider.

Client or Guardian Signature:_____ **Date:**_____