

**Breast cancer can be very expensive, especially for those with limited incomes. For many people undergoing treatment for breast cancer, paying for care can be a major cause of stress. Every treatment, doctor’s appointment, hospital stay, and procedure adds up, even if you have good health insurance coverage-and if you don’t have insurance or your insurance doesn’t cover much, paying medical and everyday bills can sometimes seem impossible.**

**Being in treatment can mean it’s hard to cover the cost of:**

**Mortgage/Rent:** mortgages in Default will not be considered.

**Utilities:** gas, including propane, electric, water

**Phone:** home/cell phones/internet services

**Medical Expenses**: will only be considered for patients without insurance for the expenses that pertain to the treatment of breast cancer.

**Insurance:** monthly premiums for self-insured/self-pay policyholders (not co-pays) uncovered treatment expenses that only pertain to breast cancer. Car payment, car insurance will be included.

**BellaBCF** cannot cover personal loans or credit cards.

**Bella Assistance Funds** will be approved to cover living expenses only: The below expenses must be in the patient &/or spouse’s name.

Our preference is to assist with living expenses as patients are experiencing financial need due to breast cancer treatments. Individuals must be African American and a Knoxville, TN residents for no less than one year, and US Citizens.

Individual must be in active treatment for Breast Cancer and have not received a previous funds from **BAF**. Active treatment defined as surgery, radiation therapy and or chemotherapy, **excluding long-term hormone therapy**, (including Tamoxifen, Fareston, Arimidex, Aromasin, Femara, Zoladex/Lupron, Megace, and Halotestin), alternative medicines and palliative treatment. If no treatment (chemo or radiation) after mastectomy, request for assistance must be within four (4) weeks post-surgery.

Service providers will be paid directly within 30 business days upon receipt of completed application with valid documentation and after committee approval. **No funds are given directly to applicant.**

Assistance will be limited to onetime (once in a lifetime), and an individual shall not receive funds in excess of $500. In extreme circumstances, **BellaBCF** will consider a special request, however, such requests must be approved by the **BAF** Committee as well as the complete Board. Payments for these types of circumstances may be delayed and will be dependent on annual **BAF** budget and number of requests we have received within that calendar year.

A member of your healthcare team must complete the Healthcare Provider Verification Form. Must be completed by a member of your health care team. (Doctor, nurse navigator, social worker, etc.) this is just to confirm your breast cancer diagnosis for our **BellaBCF.**

**BellaBCF** believes that self-care is a vital to the journey to recovery, **BellaBCF** will also provide a onetime facial massage with one of our supporters.

Approval of assistance is at the discretion of the **BAF** Committee. Applicant must meet Federal Poverty Guideline by Annual Income. Application Process will be open quarterly on our website.

**Bella Breast Cancer Foundation Application**

**For Bella Assistance Fund (BAF)**

**10090 DoubleTree Drive, Knoxville, TN 37932.**

Bella Breast Cancer Foundation (**BellaBCF**) financial assist is at the discretion of the **BAF** Committee. To be considered, individuals must; be in active treatment for breast cancer, African American lives in Knoxville, TN residents, US Citizen, and met our criteria. Assistance may be awarded, if approved, for rent, mortgage payments, utilities, car payment, insurance (medical and car), phone, internet, medical and hospital bills. Contact **Mary Harris** if you have questions or need more information: phone 865-300-4095 or email **Mharris@BellaBreastCancerFoundation.org**

Patient Information:

Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *If less than one year give previous address below*

Previous Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_

U. S. Citizen: *circle one* Yes No Name & Phone of person / how you learned of Fund\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (circle one) Employer TennCare BlueCare Medicare Medicaid

Patient’s Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Dependent Children at home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer’s Phone with Area Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Date of last employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Date of last employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You or Spouse receiving Unemployment? Provide dollar amount and how long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Household Income (must provide proof): $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you receive Disability: YES or No Have you applied for Disability: Yes or No

List any other assistance you receive and the amount, including Child Support, Food Stamps, Families First or any other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting assistance for: (circle all that apply) Provide Proof of Invoice/Bill, Mortgage Statement/ Lease Agreement

**Maximum Assistance is limited to $500**

Mortgage Rent Utilities Medical/Hospital Bills Insurance Car payment Phone/Internet

Attach Proof of Income, copies of Mortgage Statement or Rental Agreement, Utility bill or Medical/Hospital bill, Insurance (no co-pay) Car payment, Phone/Internet you are requesting **BellaBCF** to pay. **\*We must have this information to complete application!**

Billing/Payment information for Request: Please provide a copy of each statements/invoices/rental agreement first and last page only with name, address, phone, and specific person to contact for: Mortgage Company (mortgages in default do not qualify), Landlord, Utilities Companies and Medica/Hospital, Car payment, phone/internet that you are reques-ting assistance for. You email **Mharris@BellaBreastCancerFoundation.org** or send copies with application in the mail.

Rent, Mortgage and Utilities must be in the name of Patient or Spouse

\*Patient is required to contact service providers and give permission for **BellaBCF** to inquire about account(s) before you return this application Cancer Information: Assistance for newly diagnosed or recently diagnosed with recurrent disease in active treatment or fill out Healthcare Provider Verification Form.

Oncologist Name/Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Oncologist Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Address Hospital/Treatment Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeon Name & Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Phone &/or email of Staff Person to Verify Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ Date of original Diagnosis: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ If Recurrence

\*\*\*\*\*\*Have you had or will you have any of the following treatment: Please provide start date and ending date \*\*\*\*\*\*

Mastectomy: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Lumpectomy: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Radiation: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Chemo: \_\_/\_\_\_\_/\_\_\_\_\_

Treatment Start Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Treatment Planned: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Treatment should be Completed: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ List any Complications or other health issues that may delay or complicate recovery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient must contact Oncologist/ Doctor and give permission for **BellaBCF** to call and inquire about diagnosis, treatment or any information needed to determine eligibility of assistance prior to returning this application.

I have contacted Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and **BellaBCF** has permission to access any relevant medical chart information needed to process my application.

Signed,

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Please sign, date, and return to **BellaBCF** or application cannot be considered for approval. 92-0907201

***Bella Breast Cancer Foundation 10090 DoubleTree Drive Knoxville, TN 37932***

***Phone: 865-300-4095***

***Email:*** [***Mharris@BellaBreastCancerFoundation.org***](mailto:Mharris@BellaBreastCancerFoundation.org)

***BellaBCF.org***