SENSE of SECURITY

Financial Security for Breast Cancer Patients

2018-2020 Application Cover Sheet

Note to Social Workers and Nurse Navigators – *while this is no longer a jointly shared application with Ray of Hope Cancer Foundation and Rocky Mountain Cancer Assistance, the forms remain virtually identical and we will continue to accept whichever form you submit for your applicant in an effort to reduce your paperwork burden.*

Complete application includes:

- Five pages of the application
- Treatment dates (beginning and ending) and type of treatment
- Copy of most recent pay stub(s) and/or award letter(s) for **all** household income
- Copies of the most recent statements for the top two priority non-medical expenses (e.g. mortgage, utility, etc.) as identified on page 4 in the "Priority of Need" column
- Applicant's signature on page 5
- Note: ***Incomplete applications will not be reviewed until requested info is received***

Sense of Security provides relief from financial hardship and enhances the quality of life for breast cancer patients in treatment. We provide assistance for housing, food, utilities, transportation, insurance, and other basic household expenses.

Do you meet our eligibility criteria?

__Yes __No I am 18 years or older

__Yes __No I am a Colorado resident

__Yes __No I have **BREAST CANCER**

__Yes __No I am currently receiving cancer-treatment in Colorado (surgery, chemotherapy, or radiation)

__Yes __No The **gross** income for everyone in my home does not exceed the income guideline below

__Yes __No I have a dire financial circumstance

*If you answered **YES** to **every** question, you are eligible to apply for assistance from SOS.*

Number of People in Household	Annual Max	Monthly Max
One	$ 30,350	$ 2,529
Two	$ 41,150	$ 3,429
Three	$ 51,950	$ 4,329
Four	$ 62,750	$ 5,229
Five	$ 73,550	$ 6,129
Six	$ 84,350	$ 7,029
Seven	$ 95,150	$ 7,929
Eight	$105,950	$ 8,829

via email at the end of the month and the applicant will be notified by mail

- A wait list exceeding six months exists.

MEDICAL VERIFICATION FORM — TO BE COMPLETED BY REFERRING PROFESSIONAL

Do not use abbreviations or codes for diagnosis and treatment. Do not send medical records.
Answer each question completely. Print clearly and use dark ink.

Parent Name (and guardian, if patient is under 18):	
Cancer diagnosis: Stage (circle): N/A 0 I II III IV A B C	
Describe current treatment:	Diagnosis Date:
Surgery ☐ Type: Date of Surgery:	Name of Physician:
Chemotherapy ☐ Begin date: Anticipated end date:	
Chemotherapy Agent(s):	
Radiation ☐ Begin date: Anticipated end date:	
Hormone ☐ Begin date: Anticipated end date:	
Patient insurance status: None ☐ Medicare ☐ Medicaid ☐ CICP ☐ VA ☐ Private ☐ Other: _____	
Has the patient applied to Sense of Security before? YES NO If Yes, When? _____	
Is patient currently able to work? YES NO	If no, what date will patient return to work?
Is patient disabled ☐ YES ☐ NO	Date of disability:
What are patient's financial needs: ☐ Utilities ☐ Medical ☐ Rent ☐ Mortgage ☐ Food ☐ Transportation ☐ Financial Assistance	
****For the application to be eligible, we must have the following contact information****	
Name of referring professional (*health care professional completing form*):	
Facility Name: Address:	
City: State: ZIP:	
Phone: ( ) E-mail:	
Do you have any reservations concerning this patient's request for financial assistance? ☐ YES ☐ NO	
Referring professional's summary regarding patient and their household's financial situation: **(This is required, please include as attachment as needed)**	
Must be signed by referring professional *(case worker, patient navigator, social worker, nurse, physician)*	
My signature below affirms the diagnosis and treatment information as described on this page.	
Signature:	Date:

PERSONAL DATA —TO BE COMPLETED BY GRANT APPLICANT *(or parent/guardian if patient is under 18)*
Answer each question completely. Print clearly and use dark ink.

Parent/Guardian name (if patient is under 18):				
Patient's Date of Birth:				Age:
Mailing Address:				Apt #:
City:		State:	ZIP:	County:
Phone	Home ( )	Work ( )		Cell ( )
E-mail address:				
Name of additional contact person with whom we may discuss your application:				
Contact information:				
I am: ☐Single ☐Partnered ☐Domestic Partnership/Civil Union ☐Married ☐Separated ☐Divorced ☐Widowed				
Gender identification: ☐Female ☐Male ☐Transgender ☐Gender non-conforming ☐Other				

These questions are optional and your answers are confidential. This information is only reported generally and anonymously, to help policymakers and advocates better understand and address health disparities in underserved groups.

Sexual Orientation: ☐Heterosexual ☐Gay/Lesbian ☐Bisexual ☐Other
Ethnicity: ☐African-American or Black ☐Asian or Pacific Islander ☐White – Non-Hispanic ☐Hispanic ☐Native American ☐Other:
Education: ☐Grade School ☐High School ☐College ☐Post-Graduate

How, when, and where is it easiest to reach you?				
Preferred language:				
I am employed: ☐Full time ☐Part time ☐Self-employed ☐Unemployed ☐ Disabled ☐Retired ☐Veteran				
If employed or disabled, who is/was your employer:				
How long have you worked for this employer?				
What kind of work do/did you do?				
After you have recovered, can you return to work for this employer? YES NO				
Is your spouse/partner employed? YES NO N/A		Type of work?		
What is the name of your spouse/partner's employer?				

List the names of all people living in your home

Name	Relationship	Age	Employment (of adults over 18)				
			Full time	Part time	Disabled	Retired	Unemployed
This applicant	**self**						

Comments

INCOME & ASSETS — TO BE COMPLETED BY GRANT APPLICANT

Tell us about your current total household income. Please report gross earnings (before taxes or other deductions). Attach copies of income documentation for your entire household (paystubs, social security letters, pension statements, etc.)

Income	Gross Monthly Amount	Start Date *(date you began receiving this income)*	End Date *(date you stopped receiving this income)*
1) Your gross monthly income from working	$		
2) Your spouse/partner's gross monthly income from working	$		
3) Other household members' gross monthly income	$		
4) Monthly disability payments:			
a) Sick leave pay	$		
b) Employer group disability insurance	$		
c) Workers' compensation	$		
d) Any personal disability insurance	$		
e) VA benefits	$		
f) SSI or SSDI *(circle one)*	$		
5) Social security retirement benefits	$		
6) Retirement, pension, 401-K or IRA	$		
7) Child support	$		
8) Spousal support	$		
9) Public assistance	$		
10) Food stamps	$		
11) Other income *(unemployment or other ongoing income)* Describe:	$		
12) Family and friends' contributions	$		
Total Gross Monthly Income	$		

EXPENSES — TO BE COMPLETED BY GRANT APPLICANT

Prioritize your expenses in the "Priority of Need" column with #1 being the most important expense.

Please list **all** of your household's expenses on this page so that we have an accurate picture of your financial situation. **Providing complete and accurate information will help us to help you.**

Monthly Expenses			
Expense	**Monthly Payment/Amount**	**Total Balance**	**Priority of Need**
Rent or mortgage →**Payment is made to: _____**	$		
2) HOA fees	$		
3) Utilities (electric, gas, water, trash service)	$		
4) Monthly food expense*: **$200/m x # in house =**	$		
5) Child care/child support	$		
6) Pet care	$		
7) Tuition	$		
8) Telephone (land/cell), TV, Internet	$		
9) Your car payment	$		
10) Your household members' car payment (s)	$		
11) Transportation *(bus pass, cab, or other expense)*	$		
12) Gasoline and oil	$		
13) Insurance:			
a) Health	$		
b) Car	$		
c) Home/renters *(if not included w/ mortgage)*	$		
d) Life insurance for you	$		
e) Life insurance for your family	$		
14) Other Non-Medical bills or payments*	$		
15) Property taxes *(if not included w/mortgage)*	$		
16) Loan repayments	$		
17) Credit card payments	$		
18) Taxes and other payroll deductions*	$		
19) Prescription costs after insurance	$		
20) Other medical costs after insurance*	$		
Total Monthly Expenses	$		

*Please describe other expenses here:

GRANT REQUEST APPLICATION —TO BE COMPLETED BY GRANT APPLICANT

Have you applied to the following agencies for assistance?
(We strongly encourage you to seek assistance from any and all agencies and resources. Assistance from other resources does not affect eligibility.)

Ray of Hope Cancer Foundation	Rocky Mountain Cancer Assistance	Project Angel Heart
Friends of Man Foundation	I Go Pink	Pink Fund
C.H.A.I.N Foundation	Orchard of Hope (Fremont Co.)	Living Journeys (Gunnison Co.)
Blueprints of Hope (La Plata Co.)	CancerCare	Other: _____

Summarize your current financial situation **(This is required).** Include as attachment as needed.

I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Sense of Security obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary a my case that might be helpful for assessing my application.
I release Sense of Security of all liabilities or claims arising out of the donation of money or services provided to me or my family.

Applicant's Signature:	Date:

☐ **By checking this box, I allow Sense of Security to use my story (minus identifying characteristics) to solicit donations/funding to further help others undergoing cancer treatment.**

APPLICATION CHECK LIST:

- ☐ **My name is on every page of this application.**
- ☐ **I have verified that my income does not exceed the guidelines listed on the application cover page.**
- ☐ **I have included all income and expense information for my entire household.**
- ☐ **I have totaled the amounts on the income and expense pages** *(pages 3 and 4).*
- ☐ **I have attached copies of household income documentation** (recent paystubs, social security letters, pension statements, etc.)
- ☐ **I have attached copies of the most recent statements for my top two (2) priority non-medical expenses (e.g. mortgage, utility, etc.) as identified on page 4 in the "Priority of Need" column. The copy includes the name on the account, the account number** *(if applicable)* **and the amount due.** *(Do not include bills for medical expenses, life insurance, credit cards, or bills payable to family members.)*
- ☐ **I have attached a copy of my photo I.D.**
- ☐ **A health care professional that is knowledgeable about my diagnosis and treatment has completed and signed page 1 of the application.**
- ☐ **I have signed this application.**