KOMEN TREATMENT ASSISTANCE PROGRAM APPLICATION

SUSAN G. KOMEN® CREATED THE KOMEN TREATMENT ASSISTANCE PROGRAM because we are committed to meeting the most critical needs of those impacted by breast cancer. The goal of this program is to help those struggling with the costs of breast cancer treatment. While medical treatment and care will be the primary cost associated with breast cancer, there are other costs that prevent an individual from receiving the care they need.

For breast cancer patients undergoing treatment with a household income at or below 250% of the Federal Poverty Level[1], a $300 award is available to help with treatment related expenses such as: rent or housing, utilities or bills, transportation to and from treatment, food or groceries, child or elder care to allow an individual to keep their appointments, home health care, medical equipment, and other medical expenses. Those undergoing active treatment for breast cancer are eligible to receive an award once every 12 months.

Instructions for Application

1. Complete the application
2. Obtain letter from patient's medical provider confirming patient is currently being treated for breast cancer
3. Submit completed application and letter from medical provider to TreatmentAssistance@Komen.org OR P.O. Box 801889 Dallas, TX 75380

Incomplete or unsigned applications will not be considered for funding

Terms & Conditions

Komen, its employees and agents are hereby authorized to obtain and discuss medical, treatment, therapy, financial, and other information relating to applicant with the applicant's healthcare providers, pharmacy, employer, insurance company, and/or any other person or entity working with Komen on the applicant's behalf for purposes of confirming the applicant's eligibility for the Treatment Assistance Program. Komen may also use or disclose the applicant's personal information as necessary for Komen to provide applicants with assistance under the program. Komen may anonymize and de-identify applicant information and data and use such information for Komen's own purposes, including to develop aggregate reports. Neither Komen nor any of its employees or agents will disclose any applicant identifiable information to any third party except as provided above, as required by law, or as deemed appropriate by Komen to investigate or resolve any potential fraud or audit irregularity.

Komen Treatment Assistance Program continuation is dependent on the availably of funds, and Komen reserves the right to modify and/or discontinue the program at any time and without any prior notice to applicants. By submitting this application, the applicant agrees to hold Komen harmless for any losses that arise, either directly or indirectly, from the applicant's to, and participation in, the Komen Treatment Assistance Program.

For assistance with the application or for more information,
contact us at 1-972-866-4233 or TreatmentAssistance@Komen.org

[1] https://aspe.hhs.gov/poverty-guidelines

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APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

First name*:_____ **Middle initial:** _____ **Last name*:**_____

Address*: _____

City*:_____ **State*:** _____ **Zip code*:** _____

Phone number: Home _____ Cell_____

Email address: _____

Date of birth*: Month_____ Day_____ Year_____
**Required*

Gender: ☐ Female ☐ Male ☐ Gender Diverse ☐ Prefer Not to Answer

Race: ☐ Black or African American ☐ White or Caucasian ☐ Asian
☐ American Indian or Alaska Native ☐ Middle Eastern or North African (MENA)
☐ Native Hawaiian or Pacific Islander ☐ Prefer Not to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer Not to Answer

Preferred language for future communications: ☐ English ☐ Spanish

BREAST CANCER INFORMATION

Date of breast cancer diagnosis: _____

Breast cancer type: ☐ Ductal Carcinoma in Situ (DCIS) ☐ Invasive Ductal Carcinoma
☐ Invasive Lobular Carcinoma ☐ Inflammatory Breast Cancer ☐ Metaplastic Breast Cancer
☐ Other (please specify): _____

Breast cancer subtype: ☐ TNBC (ER-/PR-/HER2-) ☐ TPBC (ER+/PR+/HER2+) ☐ ER+/HER2-
☐ ER-/HER2+ ☐ Unknown ☐ Other (please specify): _____

Current stage: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Undesignated

First time breast cancer diagnosis: ☐ Yes ☐ No

Breast cancer recurrence: ☐ Yes ☐ No

Treatment(s) received in the past 12 months: ☐ Chemotherapy ☐ Radiation ☐ Surgery
☐ Hormone Therapy ☐ Palliative Care ☐ Other (please specify) _____

Are you currently participating in a clinical trial for breast cancer: ☐ Yes ☐ No

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HEALTH INSURANCE INFORMATION

Please indicate type of insurance the patient has. If patient is uninsured select, 'Uninsured' (check all that apply): ☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Charity Care ☐ VA Program ☐ Medigap or Medicare Supplement ☐ Unknown ☐ Uninsured

Patient's monthly out-of-pocket costs for breast cancer treatment: $ _____

Patient's monthly out-of-pocket costs for breast cancer treatment related prescriptions: $ _____

_____

HOUSEHOLD FINANCIAL INFORMATION

Employment status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

Family income sources (check all that apply): ☐ Salary ☐ Social Security ☐ Pension ☐ Retirement Savings ☐ Short or Long-term Disability ☐ SSD (Disability) ☐ Unemployment ☐ Family or Friend Support ☐ Other (please specify): _____

Number of people in household*:_____ **Current total annual household income*†:**_____

**Required.* *†Eligible applicants must have household income at or below 250% of the Federal Poverty Line (FPL)*

Persons in Family/ Household	250% of the 2020 Federal Poverty Line (FPL)		
	48 Contiguous States and D.C.	Hawaii	Alaska
1	$31,900	$36,700	$39,875
2	$43,100	$49,575	$53,875
3	$54,300	$62,450	$67,875
4	$65,500	$75,325	$81,875
5	$76,700	$88,200	$95,875
6	$87,900	$101,075	$109,875
7	$99,100	$113,950	$123,875
8	$110,300	$126,825	$137,875

HOW DID YOU HEAR ABOUT THE SUSAN G. KOMEN TREATMENT ASSISTANCE PROGRAM?

☐ Hospital/Healthcare Provider (e.g. Doctor, Nurse, Patient Navigator, Social Worker)
☐ Internet/Radio/TV ☐ Local Komen Affiliate ☐ Family/Friends/Another Patient
☐ Social Media ☐ Komen Breast Care Helpline (1-877-GO KOMEN)
☐ Other (please specify): _____

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FINANCIAL ASSISTANCE NEEDS

(Please select your most urgent treatment related financial need): ☐ Transportation
☐ Rent or Housing ☐ Utilities or Bills ☐ Food or Groceries ☐ Lymphedema Supplies or Care
☐ Oral Treatment Medication (e.g. Chemotherapy, Hormone Therapy, etc.)
☐ Palliative Care ☐ Child Care ☐ Elder Care ☐ Home Health Care
☐ Side-effect Management Medication (e.g. Pain, Anti-nausea, etc.)
☐ Durable Medical Equipment (e.g. Oxygen Tank, Walker, etc.)

PAYMENT INFORMATION

Please provide your banking information if you would like to receive awarded funds electronically.

Electronic payments are more secure and can be processed and received faster than a check in the mail

Account Type: ☐ Checking ☐ Savings

Bank Name: _____

Name on Account: _____

Routing Number: _____

Account Number: _____

I, _____*, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms and Conditions of the Komen Treatment Assistance Program. By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

Patient Signature*: _____ **Date*:** _____

If not patient: First name: _____ Last name: _____

Relationship to patient: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member
☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider
☐ Other (please specify): _____

**Required*