FINANCIAL ASSISTANCE PACKET

The Treva Hoffman Foundation
P.O. Box 367
Winchester, OR 97495

www.thethf.com

The Treva Hoffman Foundation

Financial Assistance Program

The Treva Hoffman Foundation is a non-profit 501(c)(3) tax exempt organization funded entirely by contributions from the generosity of individuals and corporations. It is our goal to offer short term financial assistance to Oregon residents who are under-going current treatment for breast cancer with demonstrated financial needs. Financial assistance provided under this program must be directly related to the care and treatment of breast cancer.

GRANT REQUIREMENTS AND GUIDELINES:

Patient must be a resident of the State of Oregon.

Patient must have a cancer diagnosis and have been in active treatment within the last twelve (12) months, i.e.: chemotherapy, radiation, bone marrow transplant, hospice or palliative care. Active treatment does not include surgery.

The Medical Release Form must be signed by the patient.

The Medical Information Form must be completed by a health care professional.

Funds are limited and based on availability and applicants needs. Type and amount of assistance will be determined on a case by case basis by The Treva Hoffman Financial Aid Review Committee.

Submission of an application does not insure that the requested assistance will be granted.

Applicants will receive a response within 30 days upon receipt of application and required financial documents.

ELIGIBLE REQUESTS:

The Treva Hoffman Foundation approves requests for help with medical bills, prescriptions, alternative treatments, and basic living expenses such as rent or mortgage, food, utilities and travel related expenses.

Assistance for alternative treatments will be considered on a case by case basis.

INELIGIBLE REQUESTS:

We do not grant funding requests for expenses that are not directly related to receiving the care and treatment for breast cancer as prescribed by your oncologist. Reimbursement will not be made for services prior to grant award notification, unless specifically requested and approved by the grant committee. Applications with ineligible requests will receive an immediate letter of response.

ADMINISTRATION:

Checks will be payable to the provider and returned to the patient to submit when applicable. Direct reimbursement to patients will only be made with proper documentation.

WHAT YOU NEED TO COMPLETE THIS APPLICATION:

- Social Security Number
- Oregon Driver's License
- Outline of your finances, assets, income and expenses
- Name and policy number of current commercial health benefit plan
- Description of medical condition
- Description of medical treatment, therapy, equipment or services prescribed
- Prescribing physician statement of diagnosis/treatment plan
- Your out-of-pocket costs for treatment, therapy, equipment or services
- How much, if any, your commercial health benefit plan will pay
- Primary Physician's name, phone number and address
- Other agencies that you have applied for or are receiving assistance from

ALL PAGES OF THE APPLICATION MUST BE COMPLETED AND SIGNED in order to be processed.

***Incomplete applications** will **not** be reviewed.

The Treva Hoffman Foundation

APPLICATION FOR FINANCIAL ASSISTANCE

*** PLEASE COMPLETE THIS FORM IN IT'S ENTIRETY. An incomplete application cannot be processed.

Name: _____ D.O.B._____/___/_____ Soc. Sec. _____-____-____
PLEASE PRINT

Address:_____City: _____ State:_____ Zip:_____

OR Driver's Lic. # _____ Phone: _____Email:_____

Employer: _____ Phone:_____ Address: _____

Health Insurance: _____ Policy No.: _____ Deductible:_____

Co-Payment:_____ Medicare/Medicaid/OHP:_____

Spouse:_____ Dependants:_____

Spouse's Employer:_____ Phone:_____ Address:_____

Spouse's Health Insurance: _____ Policy No.:_____Deductible:_____

Deductible:_____Co-Payment:_____Medicare/Medicaid/OHP:_____

Combined Total Household Yearly Income: _____

Medical Diagnosis: _____

_____

_____

Physician:_____ Phone:_____

Address:_____ City:_____ State:_____

Describe treatment, therapy and equipment prescribed for which you need assistance: _____

_____

_____

List out of pocket expenses incurred for treatment, therapy and equipment for which you need assistance: _____

_____

_____

Please state what type of assistance you are receiving/applying for from other agencies. Provide name of agency, phone number, address and contact person:

_____

_____

APPLICATION FOR FINANCIAL ASSISTANCE (cont.)

Amount Requested: $ _____

I hereby certify that I have been diagnosed with breast cancer and require financial assistance. I also certify that the above information is true and accurate to the best of my ability. I further understand that falsification of information will result in denial of my application and that I will be held responsible for the reimbursement of any grant funds awarded based on false information. All information is considered confidential and will be used only for eligibility determination.

_____ _____

Signature of Patient/Family Member/Other Date

**** Please attach copies of Oregon Driver's License, Insurance Cards, Year End Pay Stubs, most recent W2 or Oregon tax return to show combined household yearly income.**

**** BE SURE TO FILL IN AND SIGN ALL PAGES WHERE INDICATED OR WE CANNOT PROCESS YOUR REQUEST.**

PLEASE RETURN TO: The Treva Hoffman Foundation
P.O. Box 367
Winchester, OR 97495

EMAIL: info@thethf.com

FINANCIAL INFORMATION

****COMPLETE THIS FORM IF AMOUNT REQUESTED EXCEEDS ALLOWED LIMITS**

Amount Requested: $ _____

		Monthly Income		Monthly Expenses
Employment:	Patient:	$ _____	Rent/Mortgage:	$ _____
	Spouse:	$ _____	Utilities:	$ _____
	Other:	$ _____	Food:	$ _____
Retirement:	Soc. Sec.:	$ _____	Health Ins:	$ _____
	VA Pension:	$ _____	Home Ins:	$ _____
	Employee Pension:	$ _____	Car Ins:	$ _____
Other Income:	Alimony:	$ _____	Medical:	$ _____
	Child Support:	$ _____	Auto Payment:	$ _____
	Investments:	$ _____	Credit Card Debt:	$ _____
	Public Assistance:	$ _____	Other Expenses:	
	Workman's Comp:	$ _____	_____	$ _____
	Unemployment:	$ _____	_____	$ _____
	Disability:	$ _____	_____	$ _____
	Insurance:	$ _____	_____	$ _____
	Savings:	$ _____	_____	$ _____

Assets: (If more space is needed, please attach separate sheet) Value:

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

MEDICAL INFORMATION FORM

To be completed **ONLY** by Health Care Professional

Date: _____

PATIENT INFORMATION:

First Name: _____ Last Name_____

Birthdate: _____ / _____ / _____ Gender: M _____ F _____ Soc. Sec. ____ - ____ - ____

Diagnosis: _____ Stage: ____ Date of Diagnosis: _____

Are you in active treatment? _____

If yes, please indicate type and frequency of treatment (please check all that apply)

_____ Chemotherapy _____ Radiation _____ Palliative _____ Hospice

Frequency of treatment (explain): _____

_____ Clinical Trial _____ Hormonal _____ Complimentary/Alternative

Frequency of treatment (explain): _____

CLINIC INFORMATION:

Hospital/Clinic: _____ Oncologist: _____

Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

Print name of person completing this form: _____
PLEASE PRINT

Signature of person completing this form: _____

Phone (if different from above) _____ Email: _____

Doctor, Nurse or Social Worker Recommendation for Assistance: _____

_____

_____

_____

_____

MEDICAL RECORD RELEASE & AUTHORIZATION

Oregon and Federal law protect the privacy and confidentiality of an individual patient's medical records. In order for The Treva Hoffman Foundation to access your medical records (as part of it's financial assistance process), a Release and Authorization form must be executed and submitted to your health care provider(s). Please note that you are afforded the following rights with respect to the Release and Authorization:

- You may refuse to sign the Release and Authorization form (you will be ineligible to receive financial assistance).
- You may revoke the Release and Authorization form by submitting a written revocation to the health care provider.
- The revocation will be effective upon receipt by the health care provider.
- You have a right to receive a copy of this Release and Authorization upon written request.
- You may inspect or obtain copies of all information which The Foundation receives pursuant to this Release and Authorization.

I hereby authorize my health care provider to release any health care and billing information regarding my breast cancer treatment, diagnosis, prognosis, etc. to The Treva Hoffman Foundation in determining my eligibility for financial assistance.

This Release and Authorization shall expire twelve (12) months from its execution, if not revoked prior thereto.

_____ _____

Applicant's Signature Date