



APPLICATION FOR ASSISTANCE

The Komen Wisconsin Breast Cancer Assistance Fund provides financial assistance individuals diagnosed with breast cancer and for those seeking breast health services as recommended by a medical provider who reside in or receive treatment in 22 counties in Wisconsin who are at or below 400% of the federal poverty level. Detailed information on the Fund can be found on KomenWisconsin.org/Fund

To be considered for assistance, ***please make sure that all sections of this application are complete. All required documentation and signatures must be included.***

Send the completed application to:

Janet Johnson
Wisconsin Women’s Health Foundation
2503 Todd Drive, Madison, WI 53713
Phone: 877.910.PINK (7465)
Fax: 608.251.4136
Email: wwhf@wwhf.org

Personal Information

First Name: _____ Last Name: _____ Today’s Date: _____
Address: _____ City, State, Zip: _____
County: _____
Day Time Phone Number: () _____ Email Address: _____
Age: _____ Date of Birth: _____ Female Male Transgender
Ethnicity: White African American Latino Asian American Indian Other _____
How did you hear about this fund? _____

Assistance Request

- Check here if you are applying for assistance to obtain a mammogram or clinical breast exam.
- Check here if you are applying for assistance to obtain a diagnostic mammogram, ultrasound, biopsy or another diagnostic testing.
- Check here if you have been diagnosed with breast cancer and have questions about assistance for health insurance co-payments, deductibles, premiums, rent/mortgage, gas cards/bus passes, car payment, childcare, medication, and lymphedema supplies.

Applications must be approved before services are obtained. Services must be obtained during the current grant year. All payments will be made directly to the service provider.

Health Care Provider - Medical Information

Physician's Name: _____ Hospital / Clinic: _____

Address: _____ City, State, Zip: _____

Phone Number: () _____ Fax Number: () _____

Date of Breast Cancer Diagnosis (if applicable) _____

Health Insurance Information

Do you have health insurance? Yes No

If yes, type of insurance: (check all that apply)

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Health Insurance through employer or purchased privately | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Wisconsin Well Woman Coverage | <input type="checkbox"/> BadgerCare |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Medicare |

Financial Information

Number of individuals in household: _____ (for example, the number you claim on your income tax return.)

What is your Household Annual Gross Income: \$ _____ (for example, the amount you record on your income tax return.)

(Household Annual Gross Income (before taxes); except for farm families and self-employed persons for which Net Taxable Income is used.)

Documentation of income is required for this application enclose one of the following:

- | | |
|---|--|
| -Pay Stub (<i>last two pay stubs from each income earner</i>) | -Disability Reward Letter (<i>SSI, etc.</i>) |
| -Income Tax Form (<i>W2 form or last filed income taxes</i>) | -Unemployment Statement |
| -Letter from Employer Verifying Income | |

If you currently do not have an income, please provide a brief written statement below that explains how you are supporting yourself and/or your family. Use reverse side if additional space is needed.

Medical Record Release and Authorization

Federal law protects the privacy and confidentiality of an individual patient's medical records. In order for the Komen Wisconsin Breast Cancer Assistance Fund to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be signed. 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, although you will then be ineligible to receive financial assistance from this fund.
- 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 the right to receive a copy of this Release and Authorization upon written request.
- You may inspect or obtain copies of all information which the WWHF/Komen Wisconsin Breast Cancer Assistance Fund receives pursuant to this Release and Authorization.

I hereby authorize _____
(Name of Health Care Provider)

to release all health care and billing information regarding my breast health to WWHF/Komen Wisconsin Breast Cancer Assistance Fund, 2503 Todd Drive, Madison, WI 53713.

I specifically authorize the release of all my health care and billing information to your organization's possession.

The purpose of this request is to assist the Komen Wisconsin Breast Cancer Assistance Fund/WWHF in determining my eligibility for financial assistance.

This Release and Authorization will expire twelve (12) months after it is signed unless it is revoked prior to expiration.

The Komen Wisconsin Breast Cancer Assistance Fund will not disseminate or release your medical record to any outside source without first obtaining your prior express consent.

Signature of Applicant

Date

Application Release and Authorization

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of the WWHF/Komen Wisconsin Breast Cancer Assistance Fund or Susan G. Komen Wisconsin Affiliate regarding the assistance I am requesting.

I understand and grant permission to all my doctors, clinics and hospitals to provide the WWHF/Komen Wisconsin Breast Cancer Assistance Fund documents relating to treatment and care for breast cancer as necessary. Komen Wisconsin Breast Cancer Assistance Fund agrees that all medical information will remain confidential and any reports written about the program will not use any participant's name without their express consent.

I understand and agree that fulfillment of assistance may result in publicity whether or not the Komen Wisconsin Breast Cancer Assistance Fund actively takes steps to publicize its service.

I understand and recognize that the granting of any service and the participation of any person in the assistance fund is contingent upon approval by the WWHF/Komen Wisconsin Breast Cancer Assistance Fund.

I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of services being requested and offered.

Signature of Applicant

Date

Acknowledgement of Reimbursement Waiver and Release of Claims

I, the undersigned, in consideration of my desire to obtain funds for breast health screening, diagnostic services and other eligible expenses, direct or indirect, related thereto (collectively, the "Eligible Expenses"), as determined by Wisconsin Women's Health Foundation, Inc., a Wisconsin non-profit corporation ("WWHF"), in its sole discretion, from

Komen Wisconsin Breast Cancer Assistance Fund (the "Fund"), I affirmatively acknowledge that: (i)

WWHF's sole function is to process payments and perform other administrative matters relating to the Fund, (ii) the Fund will pay up to, and no more than, **\$2,000 (the "Maximum Amount")**, for Eligible Screening and Diagnostic Expenses, and will pay up to, and no more than, **\$1,250 (the "Maximum Amount")**, for Eligible Breast Cancer Treatment Expenses; and (iii) any and all expenses that are (a) not Eligible Expenses, or (b) greater than the Maximum Amount, shall be my sole responsibility and obligation (and for the avoidance of doubt, WWHF shall have no obligation to pay any expenses other than the Eligible Expenses or pay any expenses greater than the Maximum Amount). I understand I am free to discuss with my physician(s) the whole range of options for my care and that nothing in this agreement precludes or prevents me from doing so. I also acknowledge that some options are not 'Eligible Expenses' under this program.

I agree on behalf of myself, my spouse, my heirs, assigns, related individuals and related entities, to hereby release, waive, absolve, discharge and agree to hold harmless WWHF, and its directors, officers, employees, agents, insurers, related individuals and related entities (collectively, the "Released Parties"), from and against any and all rights, claims, demands, causes of action, obligations, suits, liens, damages or liabilities of any kind and character whatsoever, whether known or unknown, suspected or claimed, which I shall or may have in the future against the Released Parties arising out of, based on, related to or connected with: (a) WWHF, (b) the Fund, (c) the payment or nonpayment of Eligible Expenses, or (d) the delivery, or lack thereof, of any and all healthcare services by healthcare service providers (including, but not limited to, any health related issues discovered, diagnosed, arising from, related to the services rendered by healthcare service providers pursuant to this Acknowledgement of Reimbursement Waiver and Release of Claims (the "Acknowledgement"). I also agree to indemnify and hold the Released Parties harmless from the payment of any and all judgments, settlements, costs, disbursements and attorney fees that are associated with the Released Parties having to defend or investigate any claim, action or proceeding of any type whatsoever arising out of the payment or nonpayment of Eligible Expenses or the delivery, or lack thereof, of any and all healthcare services by healthcare service providers pursuant to this Acknowledgement.

IN NO EVENT SHALL WWHF OR SUSAN G. KOMEN WISCONSIN BE LIABLE TO YOU FOR ANY INDIRECT, INCIDENTAL, PUNITIVE, CONSEQUENTIAL, SPECIAL OR EXEMPLARY DAMAGES OF ANY KIND OR NATURE WHATSOEVER. IN NO EVENT SHALL WWHF'S OR THE FUND'S MAXIMUM AGGREGATE LIABILITY EXCEED THE MAXIMUM AMOUNT. YOU HEREBY WAIVE YOUR RIGHTS TO BRING ANY CLAIM AGAINST WWHF OR THE FUND ARISING IN ANY WAY FROM OR RELATING IN ANY WAY TO THIS ACKNOWLEDGEMENT OR THE PROVISION, OR LACK THEREOF, OF ANY HEALTH CARE SERVICES.

This document is made, executed and entered into and shall be governed by the laws of the state of Wisconsin. I expressly consent to the venue and jurisdiction of the Wisconsin courts with respect to any dispute arising out of this Acknowledgement.

I HAVE READ THIS DOCUMENT CAREFULLY AND I FULLY UNDERSTAND ITS TERMS AND CONDITIONS.

Signature of Applicant

Date

Print Name

Interpreter Services

Do you need an interpreter? **No** (end here) **Yes** (complete below)

I, _____ (*Applicant's name*) grant permission to the WWHF/Komen Wisconsin Breast Cancer Assistance Fund to use an interpretation service to translate our conversations as part of its financial assistance process. I understand that I am entitled to these services at no cost to me or my family. I understand that this interpreter will not act as my authorized representative.

OR

Waiver: Rather than using an interpretation service, I am choosing to provide my own interpreter at this time. The name of the interpreter is _____. This person is 18 years old or over. This person will provide services to me beginning on _____ (start date) through _____ (end date). This person can be reached at () _____ (telephone number).

- I understand that I can end ("revoke") this waiver at any time and be able to use the service of an interpreter at no cost.
- I also understand that this waiver does not give permission for any interpreter to act as my authorized representative.

Signature of Applicant

Date