Mail Completed form to:
Gouverneur Breast Cancer Fund
PO Box 64
Gouverneur, NY 13642

APPLICANT FORM

Patient #

GOUVERNEUR BREAST CANCER FUND

Quality of Life Assistance Application

Gouverneur Breast Cancer Fund Provides Assistance to Legal Residents of New York State,
Counties of, St. Lawrence, Jefferson, Lewis and Franklin Only

CONFIDENTIAL - TO BE COMPLETED BY THE APPLICANT - PLEASE PRINT

Section 1: Patient Information

Patient Name: _____ Date of Birth: _____ Gender: M / F

Address: _____

City/Town: _____ State: _____ County: _____ Zip: _____

Email Address: _____

Home Phone:( ) _____ Work Phone:( ) _____ Mobile Phone:( ) _____

Is it okay to leave a message with someone: Y / N — or on an answering machine/voicemail: Y / N

Patient Employer: _____

If patient is a minor, please list parent(s) or guardian(s) name(s): _____

Insurance Information

Do you, the patient have insurance? Y / N — If Yes, Person's name it is under: _____

Insurance Co.: _____

Do you have a secondary Insurance? Y N — Medicaid: _____ Medicare: _____ Veteran: _____

Name of Person Completing Form: _____ Relationship to Patient: _____

Address: _____ City/Town: _____ State: _____ Zip: _____

Home Phone:( )_____ Work Phone:( ) _____

Emergency Contact Person: _____ Relationship to Patient: _____

Home Phone:( ) _____ Work Phone:( ) _____Cell Phone:( ) _____

Section 2: Assistance Request

Please Mark Box for Request

- ☐ Transportation for Treatment
- ☐ Dependent Care during Patient treatment
- ☐ Cancer Related Medication, Deductibles and Dr. Expenses
- ☐ Other:(Household Expenses):

FIRST TIME APPLICANTS MUST PROVIDE PROOF OF RESIDENCE, SUCH AS A TAX OR UTILITY BILL

RECEIPTS ARE REQUIRED FOR REIMBURSEMENT. FIRST TIME APPLICANT FOR TRANSPORTATION DOES NOT NEED RECEIPTS

Section 3: Treating Physician Information:

Physician's Name: _____

Address: _____City/Town: _____State: _____Zip: _____

Office Phone No.: _____ Office Fax No.: _____

Section 3: Patient Release of Information

I HAVE CONTACTED THE GOUVERNEUR BREAST CANCER FUND FOR ASSISTANCE AND HEREBY AUTHORIZE MY DOCTOR TO RELEASE INFORMATION REGARDING MY (OR MY CHILD'S) ILLNESS AND ITS TREATMENT TO THE GBCF ADMINISTRATOR(S). I AM SUBMITTING THIS APPLICATION FOR EMERGENCY ASSISTANCE DUE TO THE FINANCIAL BURDEN INCURRED AS A RESULT OF BREAST CANCER.

Date: _____ Applicant's Signature: _____