Information and Documents and Requirements

The following documents will need to be submitted by applicant along with the attached application: Please submit information related to anticipated reconstruction surgery.

Breastoration does not pay for the cost of reconstruction and completing this application does not guarantee that you will receive any funds or guarantee an amount.

The following documents will need to be submitted by applicant along with the attached application:

1. **Patient information and Breast cancer diagnosis information**, including timing of plans for surgery. Questions included on the application.

2. **Tax returns** for the most recent tax period; if you are not required to file a tax return please provide w-2 form or most recent statement from Social Security verifying monthly benefit.

3. **Explanation of benefits** from health insurance. A copy of insurance card or declaration page showing co-pay and/or maximum out pocket expense.

4. **Letter of specific assistance** requested, including expenses expected to be incurred and any additional information relevant to the particular financial condition or personal situation that would assist the committee in fully understanding the needs of applicant.

5. **Breast Reconstruction Information Sheet** (included in application) This form must be filled out by the Plastic Surgeon performing the reconstructive surgery.

Examples: Basic Monthly living expenses:

- Lost wages during surgery and recovery
- Rent/Mortgage
- Utilities
- Prescriptions
- Non-food grocery items (cleaning, toiletries, etc.)
- Food
- Child Care or Pet Care
- Health Insurance

CANCER ASSOCIATION OF LOUISIANA
201 Evans Rd. SUITE 119
NEW ORLEANS, LA 70123

TELEPHONE: 733-5539, **WITHIN** Metro New Orleans
TOLL FREE: 1-800-624-2039, **OUTSIDE** Metro New Orleans
FAX Line: (504) 733-0252

Patient Services Eligibility Form for the Breastoration Fund

Patient's Name ______________________________ Date of Birth: ______________________

Address ______________________________ Apartment ______________

City ______________________________, State ______________ Zip ______________

Telephone Number ______________________Email address, if applicable ______________________

Insurance Company

____

Does Your Insurance Company Pay for Outpatient Medications(s)? Yes ____________ No ____________

If Yes, What Percentage Does the Insurance Company Pay? ______________ percent is paid by the company.

Policy Number ______________________________ Effective Date ______________________

Medicare A # ______________________________ Effective Date ______________________

Medicare B # ______________________________ Effective Date ______________________

Medicare D # ______________________________ Effective Date ______________________

Medicaid Number ______________________________ Effective Date ______________________

<u>INCOME</u>: Please list Family member's name, **<u>ALL SOURCES</u>** of income **<u>AND</u>** include **<u>AMOUNTS OF EACH SOURCE OF INCOME and the most recent tax return for each person</u>**.

	Family Member's Name	Amount of Income	Source of Income and/or Place of Employment
1.			
2.			
3.			
4.			

<u>FAMILY INFORMATION</u>: Please list **<u>ALL</u>** family members who are **<u>LIVING WITH THE PATIENT</u>** and include any information about any health problems of those family members, their relationship to the patient, and ages of family member(s).

	Family Member's Name, age, relationship to patient	Health Problem, if any
1.		
2.		
3.		
4.		

STATISTICAL INFORMATION: (TO BE USED FOR STATISTICAL REPORTS ONLY)

RACE ____________________________ SEX ____________________________ NATIONALITY ____________________________

Please circle the correct choice below:

Do you currently use tobacco in any form? YES EX-TOBACCO USER NEVER USED TOBACCO
Would you like information on Quitting YES NO

INFORMATION ABOUT THE PATIENT'S ILLNESS: This may be filled out by your oncologist

All information in this section is required and must be completed

PHYSICIAN'S NAME PLEASE PRINT ____

SIGNATURE of Physician (required)** ____

DEPARTMENT'S TELEPHONE NUMBER(S) ____________________**DEPARTMENT'S FAX** __________________________

CURRENT TREATMENT FACILITY: ____

ADDRESS_______________________________________

____

PATIENT WAS DIAGNOSED WITH Stage 0 1 2 3 4 Breast Cancer of the RIGHT/LEFT/BOTH

ON ____/_____/_____ **WITH Mets to**____

2. Have you already undergone a mastectomy? If so, please state when the mastectomy took place and you underwent a single or bilateral mastectomy:

____
____
____
____
____
____

3. WHEN DO YOU EXPECT TO UNDERGO RECONSTRUCTION? ____

4. Where will you have reconstruction?

Please list, Name of Reconstruction Surgeon, Hospital (Location and Contact information for surgery)

____

____

____

5. Please **submit copies of medical bills related to the breast cancer treatment.**

**By signing this form, I represent and warrant under penalty of law that the above statements are true and correct to the best of my knowledge. I understand and agree that all decisions made by the Cancer Association of Louisiana are final. The Cancer Association will not make decisions based on the physician or hospital where I choose to receive services, I understand and agree that the Cancer Association reserves the right to make awards in any form the Cancer Association chooses, including but not limited to awards in the form of check or direct payment to landlords or utility companies. I understand that I will provide additional documentation to the Cancer Association if and when requested.

6. YES NO **I understand that my application does not guarantee that I will receive any funds or guarantee an amount.**

7. CONSENT TO RELEASE INFORMATION:

I, ____ (Print Patient Name], acknowledge and agree that the Cancer Association may provide my name, address, the amount of any award etc. that I may receive in connection with this application, to an entity that CALA has or may have a reporting obligation.

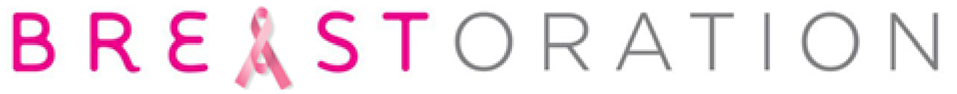
____

SIGNATURE of Patient

Today's Date (***PLEASE*** **PRINT**!!!) ____

8. If Different name and relationship of person suppling information ______________________________________

9. Please attach a statement/paragraph describing any financial hardship not listed above that may prevent you from seeking reconstruction. If there are expenses associated with that hardship, please quantify those expenses and provide documentation of those costs, if available. IF this is not enough room you may submit it on a separate piece of paper.



824 Elmwood Park Boulevard; Suite 154
New Orleans, LA 70123-3342
(504) 733-5539, **WITHIN** Metro New Orleans
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FAX: (504) 733-0252

A UNITED WAY PARTNER

Breast Reconstruction Information Sheet *Date:* ______________

Breast Reconstruction is needed as a result of a breast cancer diagnosis and mastectomy Per the requirements of CALA/Breastoration, this letter represents that I am the breast reconstruction surgeon for ____ (hereafter "Patient"). As the Surgeon, I certify that the patient is in need of reconstructive surgery of the **RIGHT/ LEFT/ BOTH [Circle One]** Breast(s) as a result of the mastectomy.

_________________________________ ____

Signature of surgeon preforming the reconstruction Printed Name of surgeon preforming the reconstruction

Mastectomy Information Check all that apply

☐ The Patient had or will have a Unilateral mastectomy on the **RIGHT / LEFT [Circle One]** breast on _______________________ **[Date].**

☐ The Patient had or will have a Bilateral mastectomy on _______________________ **[Date].**

Breast Reconstruction Information

☐ The Patient had or will have unilateral reconstruction on the **RIGHT / LEFT [Circle One]** breast on _______________________ **[Date].**

☐ The Patient had or will have bilateral reconstruction [**Circle One]** on _______________________ **[Date].**

☐ The Patient had or will have unilateral reconstruction on a single breast with a breast lift, breast reduction or
breast augmentation of the unaffected breast on _______________________ **[Date].**

☐ The Patient had a single mastectomy in the past but will have a bilateral mastectomy and reconstruction on both breasts on _______________________ **[Date].**

If you have any questions regarding this application, please call 504-733-5539 or email tammy@cagno.org

Sincerely, Tammy L Swindle