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

APPLICANT FORM

Patient # _____

Date:_____

Gouverneur Breast & Ovarian Cancer Fund

Quality of Life Assistance Application

Gouverneur Breast Cancer Fund Provides Assistance to Legal Residents of
New York State, in the 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: _____

☐ Breast Cancer

☐ Ovarian Cancer

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): _____

Section 1: 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: _____

What is your deductible? _____ What is the Co-Pay? _____ Do you have prescription coverage? _____

How have your financial circumstances changed due to your diagnosis and/or treatment? _____

_____

_____

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.: _____

What cancer treatment center is this physician associated with? _____

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 OR OVARIAN CANCER.

Date: _____ Applicant's Signature: _____