APPLICATION FOR BREAST CANCER SERVICE ASSISTANCE

Dear Applicant: Hope Lives was created to assist individuals undergoing breast cancer treatment by alleviating the physical, emotional, and financial side effects of treatment.

Reminder: Clients must be in active treatment to qualify.
PLEASE COMPLETE THE APPLICATION IN ITS ENTIRETY
AND EMAIL TO NIKKI HOUSER:
nikki@hopelives.org
or mail to 2627 Redwing Rd, Suite 160 Fort Collins, 80526

CONTACT INFORMATION

Applicant's Full Name: **First:** ______________________________ **M.I.** ______________________________
Last: ____
Nickname: _________________ **(if used other than your formal first name)**
Home Phone: __________________ **Cell Phone:** ______________________ **Work Phone:** __________________
Mailing Address: ____
City: ____________________________ **State:** ______ **County:** _____________________ **Zip:**_________________
Email: ____

Emergency Contact Name: __________________________________
Emergency Contact Phone Number: ____________________ **Relationship:** _______________________
Hope Lives reserves the right to communicate with this individual after a phone or email attempt to contact you has been unsuccessful.

WHAT SERVICES ARE YOU INTERSTED IN RECEIVING? (mark all that apply)

Therapeutic Massage	Acupuncture	Lymphatic Massage	Physical Therapy	Chiropractic Care
Biofeedback	Hypnosis	Counseling	Support Group	Energy Work
Hair	Home Services	Naturopathic Medicine	Transportation	Yoga, Tai Chi, Qigong
Wigs	Skin Care	Mastectomy Supplies	Nutrition	Body Image
Mindfulness/Meditation	Personal Trainer	Other:		

VERIFICATION OF TREATMENT

Regarding my care and treatment, I, hereby verify that I am in the care of my physician and that under his/her supervision I am receiving treatment for breast cancer in the form of:

Treatment:

- ☐ Mastectomy Date: __/___/____
- ☐ Reconstructive Surgery
- ☐ Lumpectomy Date: __/___/____
- ☐ Chemotherapy Start Date: __/__/_____
  End Date: __/__/_____
- ☐ Radiation: Start Date: __/__/_____
  End Date: __/__/_____

Please Note:
-Mammosite radiation, or hormonal therapy are not qualifying therapies.
-Reconstruction is not covered by our program.

☐ Oral Chemotherapy

☐ Other ______________________

DIAGNOSIS STATUS *I understand that it may be necessary to verify my medical status.*

DATE OF DIAGNOSIS _____/_____/_____

STAGE ____________________________

IS THIS A REOCURRANCE? □ Yes □ No
IF YES, PLEASE EXPLAIN:
____

Physician's Name (Print) ____

Social Worker/Navigator/RN Name ____

Healthcare System: UCHEALTH ☐ BANNER/MD ANDERSON ☐

DEMOGRAPHIC PROFILE

Gender Identity: Male □ Female □ Non-Binary □ Prefer not to say □

Preferred Gender Pronouns: __________________________

How do you identify racially and ethnically? ____

Date of Birth: ___/___/______ Age: ______

Marital Status: Single □ Domestic Partnership □ Married □ Widowed □ Prefer not to say □

Are you employed? Yes □ No □ Employer: ____

Do you have others living with you? Yes □ No □ If yes, how many? What is their relationship to you and age?
____

Do you have a caregiver? Yes □ No □ Do you have health insurance? Yes □ No □

Annual Household Income:
0-$10,000 □
$10,001 – 25,000 □
$25,001 – 40,000 □
$40,001 – 60,000 □
$60,001 – 75,000 □
$75,001 – 90,000 □
$90,001 – over □

How did you find out about us? ____

APPLICATION FOR BREAST CANCER SERVICE ASSISTANCE

APPLICANT AGREEMENT I, the undersigned, understand services through the Hope Lives program is a revocable gift and that Hope Lives may determine at any time to discontinue services.

I, the Applicant, have read, acknowledge, understand and agree to the following terms in order to receive benefits and services from Hope Lives:

1. I consent to Hope Lives contacting my supervising physician to verify that I have breast cancer and to verify my treatment.
2. I understand that Hope Lives provides assistance to help me be able to do household and family activities and/or to obtain goods and services. I am solely responsible for selecting and supervising desired services. I agree that I will not hold Hope Lives liable and hereby release Hope Lives and its agents, officers, directors & staff from any damages or claims that are a result of the services for which I receive benefits or reimbursement in connection with this Agreement. **3.** Hope Lives provides assistance only for the services and/or goods that I receive. Hope Lives will pay a cumulative dollar total no greater than the amount specified in the Acceptance as reimbursement for services provided to me by my third-party providers.
4. I personally, not Hope Lives, will schedule my services from all approved third-party providers. I will not seek reimbursement for services that are illegal, are unethical, are not actually received, or will be paid/reimbursed by another party. I understand and will not seek reimbursement for services provided to me by family members. Any potential third-party providers identified or named by Hope Lives or one of its agents do not constitute recommendations or any guarantee of quality service but are merely identification of third parties that claim to provide such services. Hope Lives is not responsible, and I will hold Hope Lives harmless and not liable for any damages, claims action or inaction (negligent, intentional, reckless or otherwise) of third-party provider(s) or related to any provided services or goods, when reimbursed by Hope Lives. I further agree to indemnify Hope Lives. for all damages, claims or actions related to said services, goods or this Agreement**.** **5**. Unless sooner terminated in writing by either party, this agreement shall remain in effect until my total benefit limit has been reached. Under no circumstances will Hope Lives be expected to pay, reimburse or incur expenses in excess of the total dollar value indicated on the Acceptance in regard to this Applicant, and Applicant shall refund or reimburse any amounts in excess of such value paid or incurred. **6.** The parties shall use reasonable efforts (including mediation) to resolve any differences arising between them as a result of this agreement prior to exercising their respective rights at law or equity. Applicant shall provide prompt notice to Hope Lives regarding any litigation or proceeding related to this Agreement or covered services. **7**. I acknowledge that I have read and understand this agreement and shall be bound by its terms. If Hope Lives provides assistance to Applicant, this is the entire agreement between the parties and supersedes all prior proposals and understandings between the parties. This agreement may not be modified or amended except by a written document signed by the party against whom enforcement is sought.
8. I understand reconstruction surgery or complications from reconstruction surgery is not considered treatment and are not funded by the Hope Lives program. **9.** I understand voucher certificates cannot be used for tipping a Provider.
I agree to consult with my physician and to obtain physician approval before participating in any treatment and/or complementary services provided by Hope Lives! and I release them from all liability resulting from such treatment and/or services. **10.** I understand there are no program extensions and that this is a one-time financial supportive care service program.
11. I understand any change to my Care Plan and voucher certificate usage must receive prior approval in writing. **12.** Hope Lives staff will review my program throughout the continuum of care however It is also my responsibility to be aware of current service certificates available so not to hinder future usage.

Services are a revocable gift. Hope Lives has the right to discontinue services at any time.
You must be in active treatment for breast cancer.
Hope Lives! reserves the right to verify your treatment plan with your physician, social worker, or nurse navigator.

I authorize the release of any medical information and documentation required by Hope Lives! for the purposes of verifying the information on this form and ongoing treatments.

Signature: ____ Date: ___/____/______