Reach...To...Give
Karen Hilburn Breast and Cervical Cancer Fund
P.O. Box 1462
Shelton, WA 98584

KHBCCF
P.O. Box 1462
Shelton, WA 98584
(360) 427-3623

REQUEST FOR FUNDING

APPLICANTS MUST RESIDE IN MASON COUNTY

(This is application is valid for one year from the date of submission)

Please Print Clearly:

_____

Last Name First Name Middle Initial

_____ _____

Previous Name Email Address

_____

Address: _____

_____

Home Phone Number:_____ Work Phone Number:_____

Date of Birth (mm/dd/yyyy):_____

Please tell us about your financial situation:

Total Household income before taxes $_____ per month.

How many people are supported by this monthly income? _____

Do you have health insurance: ____ Yes ___ No If yes, please specify carrier:_____

What is your health insurance deductible?: _____

What is your out-of-pocket co-pay? _____

Are you employed? ___ Yes ___ No

If you are working, who is your employer? _____

Job description: _____ Hourly Wage: _____

Do you rent or own your own home? _____

Please tell us the steps you've already taken to get financial assistance for your diagnosis and care:

Have you applied for Charity Care at Mason General Hospital? ___yes___no

Have you applied for Charity Care at another hospital in the region? ___yes___no

Have you applied for funds from the Breast and Cervical Cancer program? ___yes___no

What other funding resources have you worked with? _____

What were you told by the other agencies you tried to work with? _____

_____

_____

Please tell us why you are requesting financial assistance from the Karen Hilburn Breast Cancer Fund & indicate if you have indeed been diagnosed with breast or cervical cancer:

_____

_____

_____

_____

What are you specifically asking the Karen Hilburn Fund to assist with?

Medical bills? If so, what kind:_____

Deductibles? If so, how does your plan work?_____

_____

Help with transportation? Please explain:_____

Who is your doctor? _____

By signing this request, you are hereby consenting to the following release of information:

I hereby consent to any and all of my medical care providers, clinics, and/or hospitals, and the Karen Hilburn Breast and Cervical Cancer Fund to provide each other with information about my health care, Pap tests, breast exams, mammograms, and any related medical care I receive through the KHBCCF. I understand that this consent form expires 12 months after the date I sign this form.

Any information released to the KHBCCF will remain confidential. The information will be available to me, to the volunteer board members involved in my KHBCCF services, Mason General Hospital, the Department of Social and Health Services (DSHS) Health and Recovery Services, Health and Recovery Services Administration (HRSA), Breast and Cervical Cancer Treatment Program (as applicable).

I understand that receiving financial assistance through this program is voluntary and that I may drop out of the KHBCCF program and withdraw my consent to release information at any time.

Please attach copies of the medical bills for which you are requesting funding.

Also, please note: this application will be considered valid from one year of your signing.

Signature_____ **Date:** _____

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Karen Hilburn Fund Staff Use Only

Committee: ___Approve ___Disapprove Date:_____