SOLANO MIDNIGHT SUN FOUNDATION

795 Alamo Drive, Suite 106 · Vacaville, CA 95688
Phone: (707) 469-9909 Fax: (707) 320-0018 Website: http://www.solanomidnightsun.org

CLIENT APPLICATION FORM

Candidates for financial assistance must have been diagnosed with breast cancer, and must have a treatment plan and be pursuing that treatment plan or recovering within 2 months of the end of the treatment plan. If you have a diagnosis of metastatic breast cancer, are undergoing any form of treatment, and the disease or treatment prevents you from working, you may be considered eligible for assistance.

If you have completed surgery, chemotherapy, and/or radiation for primary breast cancer, are considered to have no evidence of disease (NED), and are now taking adjuvant Tamoxifen, Arimidex or similar hormonal treatment on a long-term basis, you are no longer considered to be in treatment for active breast cancer and are no longer eligible for assistance. If you stop treatment for any reason against your oncologist's advice, you will no longer be eligible for assistance.

Thank you for applying to Solano Midnight Sun Foundation (SMSF). Please read the following instructions before beginning the application.

1. Complete pages 2-5 of the application. Be as specific as possible with regard to income and expenses, savings, and other forms of assistance to which you may have access. Please initial the bottom of every page where indicated.
2. Pages 6 and 7 are two copies of an authorization for release of your medical information by your doctor. Fill this form out completely, and give one copy to your doctor (oncologist, surgeon - whomever you consider to be the head of your medical team). This form tells your doctor that you give him/her permission to provide information about you to SMSF and should be kept in your file. Please send one copy to SMSF along with your application.
3. Have your physician complete page 7, which will tell SMSF about your breast cancer diagnosis and treatment plan. He/she may complete the form and return it to you, or complete it and mail it directly to SMSF.
4. Submit your application to SMSF by mail or fax. Please note: Your application will not be processed until complete, including receipt of the physician report (page 7).

CRITERIA FOR ELIGIBILITY

SMSF provides support for individuals living in Solano County who are going through breast cancer treatment, and whose income and/or expenses are significantly impacted by treatment. SMSF reserves the right to verify income, expenses, and treatment plan by requesting the following information.	
VERIFICATION	**CONDITIONS**
Identification	Must provide proof of identification. Picture ID, CDL, California ID, passport, employment or school ID, or other acceptable identification and social security card.
Housing	Must be a resident of Solano County to be eligible for SMSF support. Proof of location of residence by rent receipt, mortgage payment receipt or contract, or note from landlord; utility receipts, turn-off notice, late notice, eviction notice, fore-closure notice, 3 day notice to quit, etc.
Income	Must provide verifiable income information for pre-treatment and during treatment. Earned and unearned income for spouse or other responsible persons living in the home.
Medical statement	Must be in active treatment to receive SMSF support. Current diagnosis, prognosis, surgery date, and treatment plan with date and signature of treating physician
Non-shelter expenses	Must provide information about credit payments, car payments, child care, child support, cable, furniture storage, health club, other legal obligations for spouse or other responsible persons living in the home
Vehicles	Exempt
Personal Items	Exempt
Real estate	Exempt

*****Please initial the bottom of every page of this application*****

Date of Application _____

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DEMOGRAPHIC INFORMATION

Name: _____ Date of Birth: _____

Address: _____

City, State Zip: _____

Phone number: Home: _____ Work: _____

Cell Phone: _____ Other: _____

E-Mail: _____

Ethnicity (optional): _____ Preferred Language: _____

MARITAL STATUS (please circle)

1. Married 2. Never Married 3. Separated 4. Divorced

5. Widow(er) 6. Other _____

CHILDREN

Name	Age	Birth Date	Gender (circle F or M)	Residence (circle Y or N)
1.			F M	Lives with you? Y / N
2.			F M	Lives with you? Y / N
3.			F M	Lives with you? Y / N
4.			F M	Lives with you? Y / N
5.			F M	Lives with you? Y / N
6.			F M	Lives with you? Y / N

Other Dependents Living With You

Name	Age	Relationship to You
1.		
2.		
3.		
4.		

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What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, etc.) _____

_____

Current breast cancer diagnosis – please include stage and treatment plan (in your own words)_____

_____

_____

_____

_____

Tell us your reasons for making this application: _____

_____

_____

Did someone help you with this application? ☐ No ☐ Yes

Name: _____ Relationship: _____

Phone Number: _____ Email:_____

Please list your physicians below, including name and phone number:

Medical Oncologist: _____

Radiation Oncologist: _____

Surgeon: _____

Plastic Surgeon:

_____

Please provide us with an emergency contact. The person you list should be someone that you are in contact with on a regular (daily or weekly) basis that we can call if we are unable to reach you.

Name: _____ Relationship to you: _____

Home phone number: _____ Cell phone number: _____

E-mail Address: _____

Please use this space to add any comments or information you would like to tell us: _____

_____

_____

_____

_____

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WORK HISTORY

Most recent employer: _____ Job title: _____

If not currently working, date last worked: _____ Monthly income when working: _____

CURRENT INCOME		**Monthly amount**
1.Your wages/salary *if you are currently working* (after taxes)		
1.Spouse/partner's wages/salary (after taxes)		
1.Property rental income		
1.Interest/dividends		
1.Veterans Benefits		
1.Roommate/Boarder		
1.Other		
Please indicate if you have applied for any of the following. **Circle "accepted" if you are receiving funding, "pending" if your application is in process, or "denied" if you have been denied for that program**		
8.Disability thru employer	Accepted Pending Denied	
8.State Disability Insurance	Accepted Pending Denied	
8.SSI/SSD	Accepted Pending Denied	
8.Other Soc. Sec. _____	Accepted Pending Denied	
8.Unemployment Insurance	Accepted Pending Denied	
8.Pension/Retirement	Accepted Pending Denied	
8.Worker's Comp	Accepted Pending Denied	
8.Child support/alimony	Accepted Pending Denied	
8.Care of foster child	Accepted Pending Denied	
8.In-home care/In-Home Supportive Services	Accepted Pending Denied	
8.School grants/loans	Accepted Pending Denied	
8.General Relief (Welfare)	Accepted Pending Denied	
8.Food Stamps	Accepted Pending Denied	
8.CalWORKS (AFDC)	Accepted Pending Denied	
8.Other _____	Accepted Pending Denied	
TOTAL AVAILABLE MONTHLY INCOME (add lines 1-22 together):		$

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Are you receiving funds/loans/donations, etc. from any other social services agencies in your County? ☐ No ☐ Yes

If yes, list all agencies and dates and amounts of last aid (use a separate sheet if necessary):

_____

_____

_____

_____

MONTHLY EXPENSES

1. ☐ Mortgage or ☐ Rent	
1. Gas	
1. Electricity	
1. Water	
1. Trash Collection	
1. Telephone and/or cellular phone	
1. Cable	
1. Food	
1. Auto Loan	
1. Auto Insurance	
1. Gasoline	
1. Medications (related to breast cancer treatment only)	
1. Medical co-payments and/or share of cost	
1. Health insurance premiums	
1. Other:	
1. Other:	
1. Other:	
TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 17 together):	**$**

❑ Please check this box if you would like to be referred to other agencies for possible assistance. Referrals may result in sharing your information between SMSF and other agencies.

By signing below, I agree that the above information is true and correct.

_____ _____

Signature Date

APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: _____

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_____

Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: _____

_____

_____

_____

I, _____, residing at _____

_____

_____

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization (20-8124921) specific information requested by them which I cannot provide concerning:

_____

_____

_____

_____

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation (SMSF) I have read this form and have agreed to its request prior to my signing.

_____ _____

Print name Social Security Number

_____ _____

Date of birth Birthplace

_____ _____

Signature of Applicant Date

_____ _____

Signature of Witness Date

Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Solano Midnight Sun Foundation.

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APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: _____

Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: _____

_____

_____

_____

I, _____, residing at _____

_____

_____

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization (68-0354961) specific information requested by them which I cannot provide concerning:

_____

_____

_____

_____

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation (SMSF) .I have read this form and have agreed to its request prior to my signing.

_____ _____

Print name Social Security Number

_____ _____

Date of birth Birthplace

_____ _____

Signature of Applicant Date

_____ _____

Signature of Witness Date

Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Solano Midnight Sun Foundation.

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PHYSICIAN REPORT

The individual listed below has requested assistance from Solano Midnight Sun Foundation (SMSF) and has stated that s/he is unable to work or is unable to work at pre-treatment level. A signed release for the requested information is attached.

Please complete this form and return it by: _____ (date)

Attn: Director of Client Services
Solano Midnight Sun Foundation
795 Alamo Drive, Suite 106
Vacaville, CA 95688
FAX: 707-320-0018

SECTION I			
Name:			
Date of birth:		Social Security #:	
Physician's Name:		Physician's phone:	
Physician's Address:			
SECTION II – TO BE COMPLETED BY YOUR PHYSICIAN			
Diagnosis:			
Date of onset:		Date of last appointment:	
Pertinent pathology results (attach copy of report if available):			
Medications prescribed:			
Indicate client's prognosis:			
Specific physical limitations:			
Is patient's condition suitable for employment? ☐ **Yes** ☐ **No**			
What level of employment activity is suitable for patient? ☐ Part-time ____ hours per week ☐ Full-time			
Projected date patient can return to work at pre-treatment level:			
Planned surgeries – list date and expected date of recovery:			
Other planned treatments (chemo, radiation, etc.) – list projected end date:			
Comments:			
Physician's signature:		Date Signed:	