



## Breast Cancer Care Fund

(Supported By The Central Coast Women's League)

### APPLICATION

This fund is for women who need financial assistance in paying for supplies for lymphedema treatment, or other breast-cancer-related treatment. It includes funds for compression garments, compression bandages, bras, prostheses and co-payment assistance for supplies and treatment costs. If you fit into this category of need, please fill out this application and either fax it to Enhancement, Inc. at 772-4717 or mail it to us at P.O. Box 867, Morro Bay, CA 93443-0867. There are no deadlines for sending in an application and funds will be distributed as needed and as available. A maximum of \$500.00 will be given per person per calendar year. If you have any questions, call us directly at 771-8640.

### YOUR CONTACT INFORMATION

1. Please print your full name: \_\_\_\_\_
2. Please print your mailing address: Street \_\_\_\_\_  
 City \_\_\_\_\_ Zip \_\_\_\_\_
3. Home phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Email Address: \_\_\_\_\_
4. Where did you hear about this application? \_\_\_\_\_  
 \_\_\_\_\_

### MEDICAL INFORMATION

5. When were you diagnosed with cancer? \_\_\_\_\_
6. Treatment: (check all that apply)  
 Surgery: \_\_\_\_\_lumpectomy \_\_\_\_\_mastectomy  
 Chemo: \_\_\_\_YES \_\_\_\_NO Radiation: \_\_\_\_YES \_\_\_\_NO
7. Are you presently under a doctor's care? \_\_\_\_\_ YES \_\_\_\_\_NO  
 If YES: Who is your doctor? \_\_\_\_\_
8. Did you get lymphedema as a result? \_\_\_\_\_ YES \_\_\_\_\_NO  
 If YES: When were you diagnosed with lymphedema? \_\_\_\_\_  
 How long have you been in treatment for your lymphedema? \_\_\_\_\_  
 Who is your lymphedema therapist? \_\_\_\_\_

**MEDICAL INFORMATION - CONTINUED**

8. continued:

If YES:

Are you currently wearing a compression or alternative garment?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, who provides it? \_\_\_\_\_

**FINANCIAL NEED**

14. My annual household income is:

_____ \$1,000-\$10,000	_____ \$31,000- \$35,000	_____ \$51,000-\$55,000
_____ \$11,000-\$20,000	_____ \$36,000- \$40,000	_____ \$56,000-\$60,000
_____ \$21,000-\$25,000	_____ \$41,000- \$45,000	_____ \$61,000-\$65,000
_____ \$26,000-30,000	_____ \$46,000- \$50,000	_____ \$66,000-\$70,000
		_____ \$71,000 or more

15. Number of members supported by this income? \_\_\_\_\_ spouse? \_\_\_\_\_  
# of children \_\_\_\_\_ ages of children \_\_\_\_\_

16. Do you have medical insurance coverage? \_\_\_\_\_ YES \_\_\_\_\_ NO  
If YES: What is it? \_\_\_\_ Medicare \_\_\_\_ MediCal \_\_\_\_ Private  
If Private, please state company: \_\_\_\_\_

17. Is the annual household income provided solely by one individual or is this a joint salary range? \_\_\_\_\_

18. Please list any extenuating circumstances that are stressing your household income: \_\_\_\_\_  
\_\_\_\_\_

19. Please list any other income sources, such as alimony, child support, FDIC, etc.? \_\_\_\_\_  
\_\_\_\_\_

20. What is your specific request (how much money and for exactly what purpose)?  
(Also **Fax** or **Mail** your receipt or bill with the **exact** amount you need, up to \$500.)  
\_\_\_\_\_  
\_\_\_\_\_

21. Please sign here: \_\_\_\_\_ / \_\_\_\_\_  
(your signature) DATE