Financial Assistance Program

The Statesboro Bulloch County Breast Cancer Foundation's Financial Assistance Program provides limited help for breast cancer patients without insurance or limited insurance. Assistance is based on income, assets, and other factors. Qualifying applicants may apply once per calendar year for financial assistance up to five hundred dollars ($500.00) for patient-related expenses by completing the accompanying application and submitting all necessary supporting documentation to:

SBCBC Foundation
Post Office Box 2983
Statesboro, GA 30459

Qualifying applicants must be (1) undergoing treatment for breast cancer or be a recent breast cancer survivor within the last 5 years, (2) living within Emanuel, Screven, Jenkins, Effingham, Evans, Candler or Bulloch County in the State of Georgia and (3) demonstrated financial need. Requests for reimbursement may include patient-related expenses incurred within the last six (6) months. Qualifying expenses may include full or partial reimbursement for physician expenses, wigs, patient supplies, childcare for treatment/appointments, or other treatment related expenses.

Inquiries about the SBCBC Foundation's Financial Assistance Program may be made at info@statesboropinkpower.com

Please do not send any original documents. We will not be responsible for making sure that they are returned to you. There are no appeals once an application is denied. Documentation needs to show:

- You are a resident of the State of Georgia and reside within Emanuel, Screven, Jenkins, Effingham, Evans, Candler, or Bulloch County.
- You must show proof of Medicaid application, if eligible, according to the State of Georgia eligibility requirements.
- If you have recently lost your job, please provide a copy of your unemployment income information.
- Completed Financial Assistance Application

STATESBORO-BULLOCH COUNTY BREAST CANCER FOUNDATION
FINANCIAL ASSISTANCE PROGRAM APPLICATION

A. Patient Personal Information

Name:____
Address: ____
City:______________________________State: ___________________Zip:__________
Date of Birth:_______________________ Phone: _______________________________
Race: ☐Caucasian/White ☐African American/Black ☐Hispanic
☐Asian/Pacific Islander ☐American Indian ☐Other___________
Email: ____
Employer:____
Position:____
Physician/Oncologist: ____
Current Therapy: ____

B. Patient Financial Information

Number of people in your household: Adults________Children______

Total combined income for you, your spouse, and your dependents $_________________(Annually)

******You must provide proof of income to apply******

Please provide a copy of your most recent: Federal Tax Return ***or*** Two Pay Stubs ***or*** Social Security Awards Letter

C. Patient Insurance Information

Do you have insurance? ☐ Yes ☐ No

Primary Insurer __________________________Secondary Insurer________________________________

Please submit the ***completed*** application form and all supporting documentation to:

SBCBC Foundation
Post Office Box 2983
Statesboro, GA 30459

If we do not receive all the information required, as described above, your application will be denied.

By signing this application, I certify that all the information on this application is true and accurate to the best of my knowledge. I also agree to allow the SBCBC Foundation, at their sole discretion, to check employment and credit history for the purpose of determining my eligibility.

Signature of Patient ____Date_______________________

You will be notified by mail if your application has been approved or denied. Failure to provide all required information and documentation may result in an automatic denial of application.

STATESBORO-BULLOCH COUNTY BREAST CANCER FOUNDATION FINANCIAL ASSISTANCE PROGRAM APPLICATION

How did you hear about the Statesboro-Bulloch County Breast Cancer Foundation Financial Assistance Program?

	Please select one
	Foundation’s Website
	Foundation’s Facebook
	A Flyer
	Word of Mouth
	Radio
	Newspaper
	Suggested by a Friend, Co-worker, or Associate
	Television Ad
	Other

Please provide a brief description on how you would use the funding:

STATESBORO-BULLOCH COUNTY BREAST CANCER FOUNDATION
FINANCIAL ASSISTANCE PROGRAM APPLICATION

Patient Medical Information

Patient Name:____

Must be completed by your Oncology Physician or Oncology RN

Date of Diagnosis:________________________Primary Cancer Diagnosis:________________________

New Diagnosis (Y/N) ________ Reoccurrence (Y/N) ________ In Active Treatment (Y/N) __________

If in active treatment, what type of treatment?____

If patient is not in active treatment, please indicate whether follow-up treatment is needed:

_______Yes, follow up treatment is needed in _________months.

_______No, follow up treatment is not needed.

Physician (please print):____

Signature:______________________________________Date:______________________

Telephone:______________________________________