2636 Judah, #133
San Francisco, CA 94122

Office 415.534.5931
Fax 888.377.1248
e-mail: info@senseofsecurityus.org

www.senseofsecurityus.org

Medical Release Form and Letter of Diagnosis
Breast, Ovarian, or Other Gynecological Cancer

Client Name ____ Date of Birth ____________________

Client Consent to Release Information

I authorize my medical provider to release information about my medical condition for purposes of verifying my eligibility to *Sense of Security California*.

Client Signature ____ Date of Birth ____________________

All documentation is subject to verification. Fraudulent documentation may lead to termination of services.

Provider Verification

Type of cancer *(✓)* Breast ______ Ovarian _______ Other __________________________________

Date of cancer diagnosis (Month/Year) _______________________

Clinical Stage *(✓)* Unknown ________ DCIS ________ I________ II ________ III ________ IV ________

Other ____

Date of most recent surgery (Month/Year) _______________________

Surgery Type ____

Current Treatment *(✓)* Radiation _________ Chemotherapy _________

Other ____

Date current treatment began (Month/Year) _______________________

Oncologist ____

My signature certifies the above named client has breast, ovarian or another type of gynecological cancer and is in active treatment.

____ ___________________________________

Signature of Provider (Physician, NP, LCSW, MSW, or PN) Printed Name of Provide

Medical Facility ____

Office Address ____

___________________________ _____________________________ _________________________

Date Provider Phone Provider Fax

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Criteria

To Qualify for Assistance:

Residency

You must be living in Central of Northern California for at least 6 months. (Proof: license, ID card, utility bills, lease, etc.)

Medical

You must have been diagnosed with breast, ovarian or another type of gynecological and have a *Letter of Diagnosis* (completed by an MD, NP, LCSW, MSW, or Patient Navigator).
Must be in one or more of the active treatments listed below:

- Currently undergoing chemotherapy or radiation therapy
- Within two months of surgery due to diagnosis

Financial

Income

Your total household (including all those who live in the household/family) income from all sources (including wages, government assistance, and retirement funds if you are already retired) at the time of application must be less than the median area income for the county in which you live (you do not need to look that up as we have that information).

Expenses

Additionally, your net monthly expenses, including the costs of treatment, must exceed your net income.

Assets

Your cash and liquid assets (such as CDs, stocks, mutual funds, annuities, and bonds) available to you must be less than your expenses for the duration of treatment AND you may not own secondary real property or other liquid real or personal property. Sense of Security California does not require you to sell or further encumber your primary residence, vehicle, or personal items to qualify for assistance from us. We may, however, disqualify you from receiving assistance or reduce the amount of assistance we offer if you have liquid assets that could be used to pay your expenses.

Community and Government Resources

Because Sense of Security California does not have enough resources to meet all of your financial needs, we very strongly suggest that you apply for all community and governmental resources that you could qualify for.

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Financial Information
Income and Expense

Name: ____

Monthly Household Income	**Patient**	**Spouse/Partner**	**Other**
Net Income			
Alimony/Child Support			
Welfare, SSI/SDI, Disability, HUD			
Retirement/Pension			
Food Stamps			
Other Income			
Total Income			

Please enter monthly expense for your household in spaces below.					
	$		**$**		**$**
Rent/Mortgage		Utilities: electric / gas /water		Phone: cell/home	
Groceries		Internet/Cable		Childcare	
Car Payment		Gasoline		Car Insurance	
Health Insurance Premium		Medical Costs (after insurance)		Medication Costs (after insurance)	
Life Insurance		Loan Payments			
Other expenses		Credit Card Payments			

Total Income	Total Expenses
$	$

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Application for Services

Name____ Date of Birth _____________________

Home Address ____

City _______________________________________ State ______________ Zip _________________

Cell Phone _______________________________ Home Phone:_______________________________

E-mail ____

Which phone number do your prefer we use to contact you? (✓) Home __________ Cell ___________

What is your preferred method of communication? (✓) Phone _______ Text ________ E-mail_________

Is there another person we can contact to discuss your application if we cannot reach you?

Name ____ Relationship __________________________

Phone __________________________________ Email _____________________________________

Marital Status (✓) Single _______ Married _______ Other ______________

Number of wage earners in home ____ Number of dependents _____Total number in household ______

Ethnicity (Optional) (✓) Asian Pacific____ African American_____ Hispanic/Latino_____ Caucasian_____

Native American _____ Other____

Language(s) spoken (✓) English _____ Chinese _____ Spanish _____ Other ______________________

Education level (✓) Grade School ______ High School _______ College _______ Other ____________

Health Insurance (✓) None _______ Medicaid _______ Private _______ Other ___________________

Insurance Carrier __________________________________ Monthly Premium _____________________

Insurance provided by (✓) My employer _____ Spouse/Partner's employer _____ Other ___________

Employment status **before** your cancer diagnosis (✓)

Full-Time _____ Part-Time _____ On leave ____ Self-Employed ____ Retired ____ Unemployed _______

Employment status **after** your cancer diagnosis (✓)

Full-Time _____ Part-Time _____ On leave ____ Self-Employed ____ Retired ____ Unemployed _______

Current employment status ____

If not working, when did you last work? ____

How did you hear about Sense of Security California? ____

Name of person who referred you _____________________________ Phone ______________________

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Application Directions and Checklist

Please be sure to provide all the information requested below to the best of your ability. We want to begin assisting you as soon as possible and an incomplete application could delay this process. Please call 415.534.5931 if you have any questions.

- Review *Criteria*
- Fill out the *Sense of Security California Application* completely
- Prepare the required attachments listed below
- Explore other financial resources. Because Sense of Security California will not be able to provide all the financial help you may need, we strongly recommend you explore all options for assistance during your treatment.

Required attachments listed below.

1. Proof that you live in Northern or Central California (copy of your current California Driver's License or State I.D. with an address matching your application. ☐
2. Submit first page of your rental agreement or with your name on it. (If the document is in your spouse's, partner's, or family member's name please attach an explanation.) ☐
3. Medical status verification (Submit signed *Letter of Diagnosis* - part of application) ☐

Read and verify the information before sending in application

- I understand Sense of Security California does not pay for medical expenses of any kind.
- I live in either Northern or Central California.
- I am currently a breast, ovarian, or other type of gynecological cancer patient in treatment listed in the *Criteria.*
- I understand Sense of Security California will ask personal questions about my treatment and financial status to ascertain eligibility. I agree to provide accurate answers.
- I understand the verification portion of my *Letter of Diagnosis* must be completed by my MD, NP, patient navigator, or medical social worker

Mail or e-mail your completed application and all required attachments to:

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