Patient Information *Please tell us about yourself*

LAST NAME | FIRST NAME | MIDDLE INITIAL | DATE

SOCIAL SECURITY NUMBER | DATE OF BIRTH | AGE | EMPLOYER

STREET ADDRESS | APT # | CITY | STATE | ZIP | COUNTY

HOME PHONE | WORK PHONE | RACE (for tracking purposes only)

EMAIL ADDRESS | CELL PHONE

How did you hear about the BCSS Emergency Fund? _____

Family Information *Please list all dependents in your household*

NAME | AGE | RELATIONSHIP

NAME | AGE | RELATIONSHIP

NAME | AGE | RELATIONSHIP

NAME | AGE | RELATIONSHIP

Financial Information *Please list your gross household income per month $* _____

PRIMARY SOURCE OF HOUSEHOLD INCOME | AMOUNT

OTHER INCOME | SOURCE | AMOUNT

SOURCE | AMOUNT

Medical Information

Date of breast cancer diagnosis or recurrence _____

PHYSICIAN'S NAME | PHONE

TREATMENT COORDINATOR'S NAME | PHONE

*My signature below gives **Breast Cancer Support Services** permission to contact my physician, treatment coordinator, and vendors to verify information relative to this application. To the best of my knowledge and ability, all information given is correct. I understand that if I falsify any of the information on this application, I will be automatically disqualified from receiving any financial assistance. I also give permission for BCSS to leave a message on answering devices at my phone numbers listed above..*

APPLICANT'S SIGNATURE | DATE

Applicants will be notified of their qualifying status within ten working days of Breast Cancer Support Services' receipt of written verification from your doctor's office. Original invoices or coupons are required for payment.

You may fax this application to 423-629-1733** or mail it to Breast Cancer Support Services, 1400 McCallie Ave, Suite 110, Chattanooga, TN 37404. **Questions? Call 423-629-2445.