Date: _____

Komen Treatment Access Program Patient Application

This Treatment Access Patient Application is used by 211info to process health care provider requests for assistance.

Fax the completed request to: 1-855-800-2976 or Email: komen@211info.org

PATIENT INFORMATION—PLEASE PRINT CLEARLY AND COMPLETE ALL FIELDS. MISSING INFORMATION COULD DELAY REQUEST.

Name				**Phone #1** □Cell □HM □WK **Phone #2** □Cell □HM □WK		
Address □HM □WK				**Email** □HM □WK		
City	**State**	**Zip**	**County**	**Age**	**Primary Language**	**Gender** □ F □M

Race / Ethnicity: □ African American / Black □ Asian □ White □ Hispanic / Latino □ American Indian/Alaska Native □ Native Hawaiian / Pacific-Islander □ Other: □Prefer Not to Answer

Breast Cancer Diagnosis Date (month and year):	**Breast Cancer Stage**: □ 0 □ I □ II □ III □ IV
Hospital (where receiving treatment):	**County** (where receiving treatment):

ELIGIBILITY GUIDELINES

Eligibility is as reported by the patient. Documentation is not necessary. There are no gender restrictions. To be eligible, a patient must:

1. Be actively receiving breast cancer treatment, diagnostic, or follow-up services, including support groups and navigation services.
2. Live or receive treatment in Oregon or the WA counties of Clark, Cowlitz, or Skamania.
3. Be at or below 250% of Federal Poverty Level. **Circle One** of the following incomes & number of persons in household, as reported by patient:

Number in Household	1-person	2-person family	3-person family	4-person family	5-person family	6-person family	7-person family	8-person family	Each additional person in family
250% FPL* *(monthly income)*	$2,602	$3,523	$4,444	$5,365	$6,285	$7,206	$8,127	$9,048	Add $921 per person after 8

*2019 FPL guidelines

4. Travel a minimum of 25 miles, one-way, to treatment. $100 card if miles travelled < 1,000. 1,000 miles or more qualify for $200 card.

Definitions and Guidelines

"Household" includes the applicant, applicant's legal spouse, children, unborn children of each pregnant member of the applicant's family size, and other tax dependents. **"Fiscal Year"** is April 1—March 31. **Maximum Distribution Per Request:** $400 per distribution **Maximum Distribution Per Fiscal Year:** $800 per year **Reapplication is allowed, during active treatment, up to maximum limits**. Lodging & food funds are only available, as part of transportation request, if an overnight stay is required for treatment and patient is not eligible for other lodging programs. If traveling to Clackamas, Deschutes, Lane, Multnomah, or Washington Counties, please try to arrange lodging through American Cancer Society's Hotel Partners Program (800-227-2345). *Funds are limited. Priority must be given to patients with a higher total number of miles to travel.*

Period of time for which applying: Beginning: _____ / _____ / _____ End: _____ / _____ / _____

Miles round trip to appointment: _____ X Number of appointments in this period: _____ = Total Miles: _____

REQUEST

GAS/TRANSPORTATION
□ $100 Visa Card (< 1,000 miles)
□ $200 Visa Card (>= 1,000 miles)

LODGING + FOOD *(only if patient requires overnight stay)*
□ $100 Visa Card – Lodging (if other lodging program not available for patient)
□ $100 Visa Card – Food (for overnight travel with Komen / other lodging program)

Cards usually arrive within 10 business days from date of request.

PATIENT CONSENT & APPLICATION VERIFICATION

Patient Consent: 211info cares about your privacy and protects how we use your information. By signing this form, you understand and agree to letting 211info receive and share information about you which is necessary to help in your care (e.g. assist in finding you transportation). For more information or to view the full 211info privacy policy, please visit 211info.org/privacy-policy or call 503-499-4302. Note: If the 211info patient consent policy above is read over the phone, and a patient signature is not possible, please indicate "via phone" in the signature line and write the name of the person who provided the verbal privacy policy.

Patient Signature: **Date:**

Provider Verification: All requests must be verified by an external medical provider (navigator, social worker, etc.).

"I certify that this patient has met all of the criteria outlined above and requires transportation assistance."

Verifier Signature: **Verifier Phone Number:**

Print Verifier Name: **Verifier Title:**

Verifier Email:

Form updated 5/20/2019