Sisters Network Triangle NC

BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

Dear Applicant:

The Breast Cancer Assistance Program (BCAP) provides assistance to women facing financial challenges after diagnosis. This program provides free mammograms and financial support for: medical related lodging, co-pay, office visits, prescriptions and transportation.

The form below must be completed and submitted with the REQUIRED SUPPORTING DOCUMENTS (i.e., medical bills, rent receipt, utility bill, etc.). Upon completion and submission of the form, the application process takes a minimum of 7 business days, incomplete application will be returned and will delay any decision regarding assistance.

If your application is approved you are required to do the following:

- Submit a statement of testimony to SNI which may be posted on our website within 2 weeks or sent to funders
- *Contact your local Sisters Network Chapter and become an active or associate" member. *If a chapter is located in your area.

**If these requirements are not met you will be ineligible to apply for future funding.**

It is our goal to assist you financially during your journey. Sisters Network® Inc. (SNI) is a leading voice and only national African American breast cancer survivorship organization in the United States. Our purpose is to save lives and provide a broader scope of knowledge that addresses the breast cancer survivorship crisis affecting African American women around the country.

Wellness,

Valarie C. Worthy, President
Sisters Network Triangle NC

PLEASE EMAIL APPLICATION & SUPPORTING DOCUMENTATION TO:
sisterstriangle@aol.com

Or Mail To: Sisters Network Triangle NC
PO Box 51592, Durham, NC 27717-1592

**BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION**
If approved, financial assistance payments may be made directly to the Provider.
Submission of this application does not imply nor guarantee approval of Financial Assistance
**PLEASE COMPLETE THE ENTIRE APPLICATION (PRINT CLEARLY)**
***Denotes a required field***

**PERSONAL INFORMATION**

Today's Date*: ________________First Name*:__________________________Last Name*:________________

Current address*:______________________________________________________________

City*:_______________________________________State*: _______ ZIP Code*:__________________________

Contact Number*:_____________________________ Email: _______________________________________

Date of birth* (M/D/Y)_________________

Are you a member of a Sisters Network Affiliate Chapter*? □ Yes □ No If yes, what chapter? _______________
________________________________________________________________________________

Have you received BCAP in the last 12 months*? □ Yes if yes $ ____________ □ No

**ASSISTANCE REQUESTED***
Office Visits □ Co-pay □ Medical Related Lodging □ Transportation □Prescription □ Mammogram □ Other (please describe) ______________________________________________________________

**TREATMENT INFORMATION**
Stage at Breast Cancer: _______________ Age at Diagnosis*: _______________

Treatment*: ___________________________________________________________________

Are you currently in treatment*? □ Yes □ No If Yes, Treatment dates: Start: ________ Finish: _______________

If YES, type of treatment:______________________________________________________________

**FINANCIAL STATUS**

Are you currently employed*? □ Yes □ No If NO, state reason:_________________________________

List sources of income:___________________________________________________________________

Amount of Request*: $_________Head of Household □ Yes □ No Number in Household: _______________

Annual Household Income* □under $25,000 □ $25,000-$49,999 □ $50,000-$69,000 □ $70,000+

Explain circumstances creating financial need at this time*:__________________________________
________________________________________________________________________________

**HOW DID YOU HEAR ABOUT SISTERS NETWORK® INC.?**

**Referred by:**
□ Friend / Acquaintance
□ Organization
If referred by an Organization, did they give you any assistance?: □ Yes □ No If yes, list type of assistance and amount: ______________________________________________________________

Organization Contact Name:____________________Organization Contact Email:____________

Organization Contact Phone:_________________________________________

Office Use Only: Date Rec'd: _____ Scan Date: __________ Staff: ________

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