



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,

Portia S. Hedgepeth, Interim President
Sisters Network Triangle NC

PLEASE EMAIL APPLICATION & SUPPORTING DOCUMENTATION TO:

trianglenc@sistersnetworkinc.org

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

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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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