



Kohl's Southeast Wisconsin Breast Health Assistance Fund

Application for Assistance CONFIDENTIAL

To be considered for assistance through the Kohl's Southeast Wisconsin Breast Health Assistance Fund, please make sure that all sections are complete and all required documentation and signatures are included. The intent of the fund is to ensure uninsured, underinsured and insured individuals access to much needed breast health screening and diagnostic services. Requests to pay for services already received will not be considered. Send the completed application to:

Janet Johnson
Wisconsin Women's Health Foundation
2503 Todd Drive
Madison, WI 53713
877.910.PINK (7465)
Fax: 608.251.4136
Email: wwhf@wwhf.org

Personal Information

First Name: _____ Last Name: _____ Today's Date: _____

Address: _____ City, State, Zip: _____

Phone Number: Home () _____ Work () _____

Cell () _____ Email Address: _____

Age: _____ Date of Birth: _____ Female Male Intersex

Gender Identity (check all that apply): Transgender Two Spirited Female Male Other _____

Ethnicity: White African American Latino Asian American Indian Other _____

Health Insurance Information

Type of insurance: (check all that apply)

- Uninsured
- Medicare
- Wisconsin Well Woman Program
- Private Health Insurance
- COBRA
- HIRSP
- Medicaid (please check type):
 - BadgerCare Plus / Basic
 - Well Woman Medicaid
 - Family Planning Waiver
- Other (please specify): _____

Medical Information

Date of Breast Cancer Diagnosis (if applicable) _____

Health Care Provider Information

Physician's Name: _____ Hospital / Clinic: _____

Address: _____ City, State, Zip: _____

Phone Number: () _____ Fax Number: () _____

Publicity Release

Are you willing to share your experience with Komen public relations committee? Sharing may include a print or TV story.

Yes, you have permission to use my:

Photo Story First Name First and Last Name

Signature of Applicant

Date

No, I prefer that Komen not use my personal information in their publicity efforts and wish to remain anonymous. I understand this will not in any way exclude me from receiving assistance.

Reimbursement Request for Approved Breast Health Services

This fund may be a resource of financial assistance for individuals at or below 400% of the federal poverty level without access to screening and diagnostic breast health services (i.e., screening/diagnostic mammograms, clinical breast exams, ultrasounds, and biopsies). In some cases, an individual diagnosed with breast cancer may be eligible for additional assistance with co-pays/deductibles, COBRA & HIRSP premiums, transportation to treatment, childcare during treatment, and some prescriptions.

Applications must be approved before services are obtained and before March 31, 2012. All payments will be made directly to the service provider.

Check here if you are applying for assistance to obtain a mammogram or clinical breast exam.

Check here if you are applying for assistance to obtain a diagnostic mammogram, ultrasound, biopsy or other diagnostic testing.

Check here if you have been diagnosed with breast cancer and have questions about assistance for co-pays/deductibles, COBRA & HIRSP premiums, transportation and childcare.

Medical Record Release and Authorization

Federal law protects the privacy and confidentiality of an individual patient's medical records. In order for the Kohl's Southeast Wisconsin Breast Health Assistance Fund to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be signed and submitted to your health care provider(s). Please note that you are afforded the following rights with respect to the Release and Authorization:

- You may refuse to sign the Release and Authorization Form, although you will then be ineligible to receive financial assistance from this fund.
- You may revoke the Release and Authorization Form by submitting a written revocation to the health care provider.
- The revocation will be effective upon receipt by the health care provider.
- You have the right to receive a copy of this Release and Authorization upon written request.
- You may inspect or obtain copies of all information which the Kohl's Southeast Wisconsin Breast Health Assistance Fund receives pursuant to this Release and Authorization.

Name: _____ DOB: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____ SSN: _____

I hereby authorize _____
(Health Care Provider)

to release all health care and billing information regarding my breast health to Kohl's Southeast Wisconsin Breast Health Assistance Fund, 2503 Todd Drive, Madison, WI 53713.

I specifically authorize the release of all my health care and billing information to your organization's possession.

The purpose of this request is to assist the Kohl's Southeast Wisconsin Breast Health Assistance Fund in determining my eligibility for financial assistance.

This Release and Authorization will expire twelve (12) months after it is signed unless it is revoked prior to expiration.

The Kohl's Southeast Wisconsin Breast Health Assistance Fund will not disseminate or release your medical record to any outside source without first obtaining your prior express consent.

Signature of Applicant

Date

Application Release and Authorization

Please read and sign below.

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of the Kohl's Southeast Wisconsin Breast Health Assistance Fund or Susan G. Komen for the Cure Southeast Wisconsin Affiliate regarding the assistance I am requesting.

I understand and grant permission to all my doctors, clinics and hospitals to provide the Kohl's Southeast Wisconsin Breast Health Assistance Fund documents relating to treatment and care for breast cancer as necessary. Kohl's Southeast Wisconsin Breast Health Assistance Fund agrees that all medical information will remain confidential and any reports written about the program will not use any participant's name without their express consent.

I understand and agree that fulfillment of assistance may result in publicity whether or not the Kohl's Southeast Wisconsin Breast Health Assistance Fund actively takes steps to publicize its service.

I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by the Kohl's Southeast Wisconsin Breast Health Assistance Fund.

I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of services being requested and offered.

Signature of Applicant

Date

Signature of Witness

Date

For office use:

Received Date: _____

Eligible / Ineligible Date: _____

Expiration Date: _____

Application Number: _____