APPLICATION CHECKLIST

Name of Applicant: _____

All of the following items must be included in your application package. If they are not, processing may be delayed.

Please check off each item enclosed and include this sheet in your package.

Check	Document or Description
	Completed Application
	A signed letter or verbal confirmation from a medical professional confirming diagnosis and treatment plan
	Completed HIPAA Form
	The front page of your tax returns from the previous year (*If last year's return is not yet available, (due to IRS due dates and/or extension requests), submit the return from the previous year (i.e.: 2 years ago). If married and file separately, submit both returns. If tax return not filed, submit all W-2s and 1099 forms from the previous year. SSI award letter also accepted. *If tax return not filed, please attest below.
	Completed NCCN Distress Thermometer

☐ Check if applicable: I attest that I have not filed taxes for the last 2 years.

APPLICANT'S SIGNATURE: _____ DATE: _____

MAIL OR FAX YOUR COMPLETED APPLICATION and all required documents to:

Gateway to Hope
425 N. New Ballas Rd Suite 220
Creve Coeur, MO 63141
Or Fax: 314-432-3303
Or Email: info@gthstl.org

A BREAST CANCER LIFELINE

Gateway to hope

GATEWAY TO HOPE PROGRAM APPLICATION

- ☐ Thelma's
- ☐ IPP
- ☐ Thelma's & IPP
- ☐ Lymphedema

NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____ **AGE:**_____ **MARITAL STATUS:**_____ **RACE/ETHNICITY*:**_____

ADDRESS: _____**CITY:**_____ **STATE:**_____**ZIP:**_____

COUNTY:_____**PHONE: HOME** _____ **CELL**_____ **WORK/OTHER**_____

EMAIL:_____ **OCCUPATION:** _____ **COMPANY:** _____

INSURANCE: Y ____ **N** ____ **INSURANCE TYPE:**_____ **#PERSONS COVERED:**_____ **MONTHLY PREMIUM AMOUNT:**_____

INSURANCE COMPANY: _____**POLICY HOLDER NAME:**_____

EMPLOYMENT STATUS: _____**HOUSEHOLD INCOME: ANNUAL/MONTHLY** _____

SOURCE OF INCOME: _____**# OF PERSONS IN HOUSEHOLD:** _____

TREATMENT INFO: **DIAGNOSIS AND STAGE:** _____ GENETIC TESTING: (CIRCLE IF COMPLETED) BRCA 1 +/- BRCA 2 +/-

BIOPSY DATE: _____FACILITY:_____(ER + / -) (PR + / -) (HER2 + / -) (PLEASE CIRCLE)

SURGERY INFO: PHYSICIAN: _____ FACILITY: _____ PHONE #: _____

PROCEDURE: _____(L/R/BILATERAL) DATE:_____

RECONSTRUCTIVE SURGERY:PROCEDURE & DATE:_____PHYSICIAN:_____FACILITY:_____

MEDICAL ONCOLOGY INFO: PHYSICIAN:_____ FACILITY:_____ PHONE #:_____

TREATMENT PLAN:_____

NEO-ADJUVANT (BEFORE SURGERY) START DATE: _____DATE COMPLETED: _____

ADJUVANT (AFTER SURGERY) START DATE: _____DATE COMPLETED: _____

RADIATION ONCOLOGY INFO: PHYSICIAN: _____FACILITY:_____PHONE #:_____

OF TREATMENTS PLANNED: _____ START DATE:_____ DATE COMPLETED: _____

REFERRAL SOURCE: NAME:_____TITLE (IF APPLICABLE):_____FACILITY (IF APPLICABLE):_____

SOCIAL WORKER/CASE WORKER/NURSE NAVIGATOR (OPTIONAL): NAME: _____PHONE #: _____

PATIENT'S SIGNATURE:_____**DATE:**_____

For Office Use Only

Patient FPG: _____

Eligibility Status: _____ **Date:** _____

Notes:

_____

_____

* Optional. Used for grant funding purposes only

Applicant Financial Information:

Complete financial information is required on all household members

Household Assets		**Monthly Household Expenses**	
Checking Account.	$_____	❑ Rent ❑ Mortgage	$_____
Savings Account	$_____	Phone(s)	$_____
Retirement Assets (e.g. 401k, IRA)	$_____	Utilities	$_____
Stocks & Bonds	$_____	***Transportation***	
		Auto Payment(s)	$_____
Monthly Household Income		Auto Insurance	$_____
Gross Monthly Wages	$_____	***Medical Expenses***	
Spouse's Monthly Income	$_____	Health Insurance	$_____
Additional Household Income	$_____	Misc. (Specify)	$_____
Child Support	$_____	Misc. (Specify)	$_____
Alimony	$_____		
Food Stamps	$_____		
SSI/SSD benefit	$_____		
Veterans benefits	$_____		
Other (Specify)	$_____		
Total Monthly Income	$_____		

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION ("PHI")

Patient's Name: _____ **Patient's Date of Birth:** _____

I hereby request that my health care provider identified below disclose the PHI described below to Gateway to Hope in connection with my application for assistance from Gateway to Hope.

Name of Health Care Provider: _____

PHI To Be Disclosed: _____
_____

Acknowledgment: If my medical record contains information about drug/alcohol abuse, mental health treatment, sexually transmitted diseases, HIV/AIDS testing/treatment or any other sensitive information, I agree to its release. ***Check if you do not agree to release of sensitive information described herein:*** ☐ **Do Not Agree**

Date(s) of Service of PHI To Be Disclosed: All dates of services, unless otherwise specified below:

_____

Revocation Right: I understand that I have the right to revoke this Authorization at any time by submitting a notice in writing to the above named healthcare provider at the address stated above and that the revocation will be effective except to the extent that action has already been taken in reliance on this Authorization.

Expiration: This Authorization will expire 1 year from the date of my signature below, unless otherwise specified herein:_____

Re-Disclosure: I understand that the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or state privacy requirements.

Signature: I understand that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing the Authorization. **By signing this document, I hereby authorize the above named provider to disclose my protected health information as specified in this document.**

_____ _____
Signature of Patient or Personal Representative Date

If this Authorization is signed by the patient's personal representative, indicate such representative's authority to act on behalf of the patient: _____

A BREAST CANCER LIFELINE
Gateway to hope

Thelma's Gift Fund Patient Information Form

Recipients of Thelma's Gift Fund:

- Eligible for up to **$1000 (one-time assistance and contingent on funding available)** for basic living expenses (rent/ mortgage, auto payments, auto insurance, auto repair, child care, telephone, utilities - electric, gas, sewer, water, waste management)
    - Rental agreement/lease must be provided for payment. If lease not available, patient must create rental agreement to be signed by property owner and notarized
    - Billing statements must have patient's name, account number, payable to and amount, address in which to send
    - Bills acquired prior to diagnosis will not be considered for assistance
- No payments are made automatically. Patient must submit bill for payment.
- Payments are mailed and can take 5-7 business days for processing. Please keep this in mind when considering due dates for bills.
- Billing statements can be faxed, 314-432-3303, mailed, emailed, or delivered in person during regular office hours (Monday-Friday, 9:00am – 4:00pm).
- Must be in active treatment for breast cancer: surgical procedures (e.g., single or bi-lateral mastectomy, lumpectomy, axillary dissection or sentinel node biopsy), chemotherapy or radiation

Please address questions to Gateway to Hope clinical staff at **314-569-1113**.

National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

Help for distress

Distress is an unpleasant emotional state that may affect how you feel, think, and act. It can include feelings of unease, sadness, worry, anger, helplessness, guilt, and so forth. Everyone with cancer has some distress at some point of time. It is normal to feel sad, fearful, and helpless.

Feeling distressed may be a minor problem or it may be more serious. You may be so distressed that you can't do the things you used to do. Serious or not, it is important that your treatment team knows how you feel.

The Distress Thermometer is a tool that you can use to talk to your doctors about your distress. It has a scale on which you circle your level of distress. It also asks about the parts of life in which you are having problems. The Distress Thermometer has been tested in many studies and found to work well. Please complete the Distress Thermometer and share it with your treatment team at your next visit.

The Distress Thermometer helps your treatment team know if you need supportive services. You may be referred to supportive services at your cancer center or in your community. Supportive services can include help from support groups, chaplains, social workers, counselors, and many other experts. Supportive services can also be found through the support services at right.

Support Services

National Cancer Institute's Cancer Information Service

Telephone
1-800-4-CANCER

Website
www.cancer.gov/aboutnci/cis/page1

Cancer Support Community

Telephone
1- 888-793-9355

Website
www.cancersupportcommunity.org/MainMenu/Cancer-Support

U.S. Health Resources and Services Administration

Website
www.findahealthcenter.hrsa.gov/Search_HCC.aspx

U.S. Substance Abuse and Mental Health Services Administration

Website
www.findtreatment.samhsa.gov

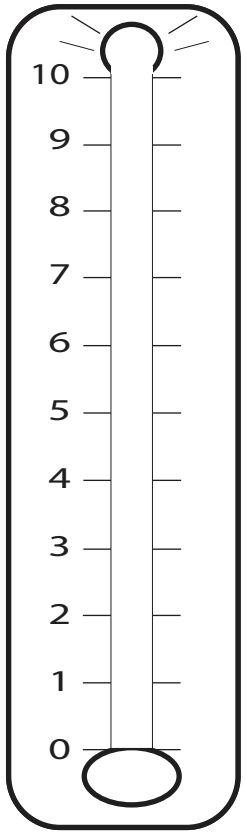
National Comprehensive Cancer Network®

NCCN Distress Thermometer for Patients

SCREENING TOOLS FOR MEASURING DISTRESS

Instructions: First please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions

YES	NO	Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues

YES	NO	Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities

YES	NO	Spiritual/religious concerns
❑	❑	

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance abuse
❑	❑	Tingling in hands/feet

Other Problems: _____

_____