THELMA'S GIFT FUND - LYMPHEDEMA

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
	Proof of household income (recent tax return, paycheck stub, disability check or award letter)

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:

_____

_____

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	$_____
Take Home Pay	$_____	***Medical Expenses***	
Spouse's Take Home Pay	$_____	Health Insurance	$_____
Additional Household Income	$_____	Misc. (Specify)	$_____
Child Support	$_____	Misc. (Specify)	$_____
Alimony	$_____		
Food Stamps	$_____		
SSI/SSD benefit	$_____		
Veterans benefits	$_____		
Other (Specify)	$_____		
Total Monthly Income	$_____		