WISCONSIN OVARIAN CANCER ALLIANCE

PERSONAL INFORMATION

Name		**DATE OF BIRTH**	
Street Address		**CITY / ZIP**	

THE CONNIE RUTLEDGE LEGACY FUND PROVIDES ASSISTANCE TO THOSE UNDERGOING TREATMENT FOR OVARIAN OR OTHER GYNECOLOGICAL CANCERS, LIVING IN WISCONSIN.
IF YOU RESIDE IN ANY OTHER STATE, PLEASE STOP HERE.

Email			
Home Phone		**Cell Phone**	

Marital Status *(check one)*	❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Partnered ❒ Separated	**# Wage Earners in Household**	
		Total # of People Living in Household	
		Number & Age of Dependents in Household	

Current Employment Status *(Please check all that apply)*

❒ Full Time	❒ Part Time	❒ Retired	❒ Self Employed
❒ Unemployed	❒ FMLA	❒ Disability	❒ Sick Leave

MY STORY

Tell us about you, your story and how a WOCA award would make a difference to you and your family during this time. Please include any information about your current or expected financial situation that you would like us to know, or that you think would help us make a decision - such as a financial hardship, excessive medical expenses, seasonal or temporary income, personal loss, or any other special circumstance that may be impacting you.

Write *Your Story* below, or feel free to attach a separate page to the application along with anything else that you may want to share with our Board as they consider your application for approval.

MEDICAL INFORMATION

PLEASE HAVE THIS PAGE FILLED OUT BY A MEMBER OF YOUR CARE TEAM
(Oncologist, Nurse Navigator, Social Worker, etc.)

Current Diagnosis:

Date Diagnosed		
Type of Cancer		
Stage/Grade		
Chemotherapy	Start Date	End Date
Radiation	Start Date	End Date

Other Therapy or Treatment Details

Form Completed by: _____

Signature / Date

_____

Printed Name *(please print)*

_____

Phone

_____

Hospital / Clinic Name

ADDITIONAL MEDICAL CONTACTS

Please provide the name, e-mail address and phone number for the following providers with whom we may discuss your application. If we can't reach you or need further information (also complete the HIPPA release form, page 7).

Surgeon / Oncologist (If separate individuals, please list both contact names)

Name			
Email			
Phone		**Hospital Affiliation**	

Name			
Email			
Phone		**Hospital Affiliation**	

Other Contact(s):

_____
_____
_____

Please read these items carefully and check the boxes that are true:

☐ I am currently a patient either recovering from a cancer-related surgery, and/or I am currently undergoing chemotherapy or radiation.
☐ I give my full authorization and permission to WOCA to obtain the necessary medical information to process my application.
☐ I understand that WOCA may ask personal questions about my treatment and financial status. I agree to provide accurate answers.

Applicant's Signature: _____ Date: _____

FINANCIAL DISCLOSURE FORM

Monthly Income	Self	Partner	Total (Partner & Self)
Salaries			
Social Security Disability and/or State Disability			
Workers Compensation			
Pension and/or Annuity Payments			
Alimony			
Child Support			
Interest/Dividends from assets / Gross rent from rentals properties			
Disability (Long Term, Short Term, SSI and/or SSID)			
TOTAL			

In order to qualify for assistance, an applicant's income restriction must be 250% or less of federal poverty levels and/or whose insurance/Medicare assistance is not sufficient for applicant to maintain financial stability.

REQUEST FOR FUNDING INFORMATION

Please rank which expenses you'd like WOCA to consider paying that would provide the most financial relief. **Please rank your priorities using numbers – starting with 1 as the most helpful**. Please note that WOCA does not pay any credit card accounts or reimburse for previous payments made.

Priority/Rank	Bill Type	Paid To
	Mortgage / Rent	
	Car Payment	
	Electric	
	Gas	
	Water/Sewer	
	Trash Service	
	Internet/Cable	
	Home Phone	
	Cell phone	
	Car Insurance	
	Other: _____	
	Other: _____	
	Other: _____	

Copies of bills/receipts must accompany this request. If bills are not included, the application will not be accepted. Unfortunately checks CANNOT be made out directly to the requestor. If approved, WOCA will make payment directly to bill recipient(s)- payments will be made online, if possible, otherwise a check will be mailed directly to the recipient(s). You will be notified how the payments are processed. Recipients are limited to a one-time disbursement up to $1000, per last submission date.

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164, "HIPPA").

1. AUTHORIZATION

I_____(*PRINT NAME*) authorize _____ _____ (*YOUR TREATING PHYSICIAN)* to disclose the protected health information described below to WOCA.

2. EXTENT OF AUTHORIZATION

I authorize the release of my health record only as it pertains to my cancer diagnosis and treatment.

3. This medical information may be used by WOCA for the purpose of evaluating my eligibility for financial aid according to their guidelines or for other purposes as I may direct.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

5. I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

SIGNATURE OF PATIENT (OR PERSONAL REPRESENTATIVE):

_____ _____

Signature Date

_____

Print Name

APPLICANT RELEASE FORM

1. I, _____

_____ : hereby grant WOCA the right to use my name (only first name) and personal information (including my story about The CRLF Financial Assistance Program and the grant/contribution that I received) for print publications, press releases, electronic media, and the internet (including the website and social media sites of WOCA).

_____ : please do not use my information in print publications, press releases, electronic media, and the internet (including the website and social media sites of WOCA).

EITHER SELECTION HAS NO IMPACT ON WOCA's DECISION TO FUND YOUR REQUEST- Please Mark with an "X".

2. I further agree and do hereby release and hold harmless WOCA from any and all claims, actions, suits, liabilities or damages arising from use of the content whether resulting from the negligence of WOCA or any other person, I waive any right I may have to make or bring any claim against WOCA relating to its use of the content. I understand and agree that I will not be compensated in any way for providing the content to WOCA or authorizing its use in the manner detailed herein.

3. Distribution of funds to any application is at the sole discretion of WOCA and its Board of Directors.

I HAVE CAREFULLY READ, CLEARLY UNDERSTAND AND VOLUNTARILY ACKNOWLEDGE THE INFORMATION SET FORTH IN THIS RELEASE FORM. I UNDERSTAND THAT THIS FORM PROVIDES WOCA WITH MY ABSOLUTE AND UNCONDITIONAL CONSENT, WAIVER AND RELEASE OF LIABILITY. BY SIGNING THIS RELEASE FORM, I UNDERSTAND IT HAS NO BEARING ON ANY DECISIONS MADE BY THE QUALIFICATIONS COMMITTEE REGARDING FINANCIAL ASSISTANCE.

Date: _____

Applicant Name: _____

Signature: _____

Please send this COMPLETED APPLICATION (all pages), plus (1) a copy of your driver's license, (2) any supplemental information requested, (3) or any additional info that the applicant would like WOCA to consider as part of their request by either:

- **MAIL to: WOCA 13825 W. National Ave. Suite 103, New Berlin WI, 53151**
- **EMAIL to: jennifer@wisconsinovariancancer.org**

The CRLF will review all applications and be in touch if additional information is required to present your application to its Advisory Board for approval. An Application for Financial Assistance will not be considered unless it is complete. Applications are presented and reviewed monthly, and you will be notified of your final application status usually within thirty (30) days of receipt.