







## Net Worth Statement

The Karen P. Nakon Breast Cancer Foundation is a tax-exempt non-profit corporation. As such, the Foundation may engage only in those activities which are charitable in nature. The Foundation may provide grants to individuals to “provide relief to the poor” or aid to individuals in “distress”. The information which you will provide on this Net Worth Statement will be used exclusively by the Foundation to determine your eligibility for financial assistance. The Foundation will not disseminate or release the provided information to outside sources without first obtaining your prior express consent.

The following financial information is being submitted by Applicant in consideration of possible financial assistance.

The figures are accurate as of \_\_\_\_\_.

Applicant signature: \_\_\_\_\_

**I. Assets:**

| A. Liquid Assets:                | Current Value |
|----------------------------------|---------------|
| Cash on Hand.....                | \$ _____      |
| Checking Account.....            | \$ _____      |
| Savings Account.....             | \$ _____      |
| Money Market Account.....        | \$ _____      |
| Certificates of Deposit .....    | \$ _____      |
| Money Market Mutual Fund.....    | \$ _____      |
| Cash Value – Life Insurance..... | \$ _____      |
| Other Liquid Assets.....         | \$ _____      |
| TOTAL.....                       | \$ _____      |

| B. Long Term Assets: | Current Value |
|----------------------|---------------|
| Trust Assets.....    | \$ _____      |
| Stocks.....          | \$ _____      |
| Bonds.....           | \$ _____      |
| TOTAL.....           | \$ _____      |

| C. Fixed Assets   | Current Value |
|---|---------------|
| Value of Residence.....                                     | \$ _____      |
| Value of Vacation/Rental Property.....                      | \$ _____      |
| Equity in Other Real Estate.....                            | \$ _____      |
| Automobiles.....  | \$ _____      |
| Other Fixed Assets / Personal Property(please explain)..... | \$ _____      |

\_\_\_\_\_

**Net Worth Statement continued**

| <b>II. Liabilities</b>   | <b>Monthly Payment</b> | <b>Balance</b> |
|--|------------------------|----------------|
| Mortgage (Principal Residence, excluding taxes).....             | \$ _____               | \$ _____       |
| Real Estate Taxes.....   | \$ _____               | \$ _____       |
| Personal Lines of Credit.....                                    | \$ _____               | \$ _____       |
| Home Equity Loans.....   | \$ _____               | \$ _____       |
| Investment Loans.....  | \$ _____               | \$ _____       |
| Other Mortgages.....   | \$ _____               | \$ _____       |
| Rent.....  | \$ _____               | \$ _____       |
| Student Loans.....   | \$ _____               | \$ _____       |
| Auto Loans.....  | \$ _____               | \$ _____       |
| Credit Card Debt.....  | \$ _____               | \$ _____       |
| Income Taxes Due.....  | \$ _____               | \$ _____       |
| Monthly Utilities (gas, electric, phone, water, sewer, etc)..... | \$ _____               | \$ _____       |
| Medical Expenses.....  | \$ _____               | \$ _____       |
| Food.....  | \$ _____               | \$ _____       |
| Other Liabilities & Expenses.....                                | \$ _____               | \$ _____       |
| TOTAL.....   | \$ _____               | \$ _____       |

**Needs Assessment**

Amount Requesting: \$ \_\_\_\_\_

For the following expenses: \_\_\_\_\_

Please note that payments are generally made to third parties (landlord, mortgage company, utility company, etc). If a grant is awarded, statements and or payment stubs will be requested in order to process payments.

Please prioritize your current needs from the list below, using a scale of 1 to 8 (with 1 being your most critical need and 8 being your least critical need):

- \_\_\_\_\_ Housing – rent or mortgage
- \_\_\_\_\_ Transportation Services
- \_\_\_\_\_ Utility/telephone payments
- \_\_\_\_\_ Nutrition or food assistance
- \_\_\_\_\_ Clothing or household goods
- \_\_\_\_\_ Prescription Medication/Treatment Costs
- \_\_\_\_\_ Other (please explain): \_\_\_\_\_

**Application Release and Authorization**

**Please read and sign below. Make sure to have your signature witnessed and dated.**

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of The Karen P. Nakon Breast Cancer Foundation regarding the assistance I am requesting.

I understand and grant permission to all my doctors, clinics and hospitals to provide The Karen P. Nakon Breast Cancer Foundation relating to treatment and care for breast cancer and other related health problems when necessary. The Foundation agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission.

I understand and agree that fulfillment of assistance may result in publicity whether or not The Karen P. Nakon Breast Cancer Foundation 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 Karen P. Nakon Breast Cancer Foundation.

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.

\_\_\_\_\_  
Participant Date

\_\_\_\_\_  
Witness Date

**Please mail the complete application to:**

**The Karen P. Nakon Breast Cancer Foundation  
35765 Chester Road  
Avon, OH 44011**

[www.nakonfoundation.org](http://www.nakonfoundation.org)  
[info@nakonfoundation.org](mailto:info@nakonfoundation.org)



## Medial Record Release and Authorization

**Ohio and Federal law protect the privacy and confidentiality of an individual patient's medical records. In order for The Karen P. Nakon Breast Cancer Foundation to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be executed 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 Authorizing Form, although you will then be ineligible to receive financial assistance from The Foundation.**
- **You may revoke the Release and Authorization by submitting a written revocation to the health care provider.**
- **The revocation will be effective upon receipt by the healthcare 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 Foundation 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 treatment to The Karen P. Nakon Breast Cancer Foundation at 35765 Chester Road, Avon, OH 44011.

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

The purpose of this request is to assist The Karen P. Nakon Breast Cancer Foundation in determining my eligibility for financial assistance.

This Release and Authorization shall expire twelve (12) months form its execution if not revoked prior thereto.

The Foundation will not disseminate or release your medical record to any outside source without first obtaining your prior express consent.

\_\_\_\_\_  
Signature of Applicant Date



## **Publicity Release**

The Karen P. Nakon Breast Cancer Foundation holds events and fundraisers throughout the year to raise money to fund the primary objectives of The Foundation: to fund breast cancer research and to help families endure the staggering costs of treatment. People do not give to The Foundation because we run fundraiser. They continue to support us because they want to see their money find its way to the people who need it the most. We need your help to put a face and a name to that reality.

To this end we ask for your permission to use your photo, your story, and a brief description of how the money that you received from The Foundation has helped you. This will assist us in communicating to our donors and help in attracting more contributors so that we can do more. Please indicate your permission by checking the appropriate areas:

- \_\_\_\_\_ Use of photo
- \_\_\_\_\_ Your background information
- \_\_\_\_\_ First Name
- \_\_\_\_\_ First and Last Name

Permission to use the checked information above is given to The Karen P. Nakon Breast Cancer Foundation for use in PR and Marketing materials which will include, but not be limited to, their Annual Report, Newsletters, Website, and general information brochures.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_ NO, I prefer that The Karen P. Nakon Breast Cancer Foundation 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.

The Karen P. Nakon Breast Cancer Foundation  
35765 Chester Road  
Avon, OH 44011  
[info@nakonfoundation.org](mailto:info@nakonfoundation.org)