



GRANT APPLICATION INSTRUCTIONS

The Karen P. Nakon Breast Cancer Foundation is a non–profit 501c3 tax –exempt organization committed to providing financial assistance to individuals impacted by the financial burden of a breast cancer diagnosis.

- This application must be complete. Answer each question or indicate with a N/A if an items does not apply to your situation. Incomplete applications will not be accepted or reviewed and will be returned.
- A current pathology report and/or treatment plan reflecting the most current diagnosis information must be included with the application or the application will be considered incomplete.
- All parties must sign and date the application in all required places or the application will not be processed.
- Type and amount of assistance will be determined on a case-by-case basis by the Nakon Foundation Board of Directors. Application submission does not assure assistance will be granted.
- The Nakon Foundation may only provide financial assistance to qualified individuals based upon a demonstration of need. The information you provide in this application will be used exclusively by the Foundation to determine your eligibility for financial assistance. The Nakon Foundation will not disclose or release the provided information to third parties without first obtaining your prior written consent.
- Approved applicant will be notified by mail and after proper billing paperwork is received, a one-time aid disbursement will be mailed directly to the third party billing entity.

Return Application and REQUIRED Pathology Report to:

The Karen P. Nakon Breast Cancer Foundation
 35765 Chester Road
 Avon , OH 44011
 info@nakonfoundation.org
 440-933-7621

Applications Postmarked by	Grants Awarded
February 20	March Board Meeting
May 20	June Board Meeting
August 20	September Board Meeting
November 20	December Board Meeting



CONFIDENTIAL APPLICATION FOR ASSISTANCE

Applications Postmarked by	Grants Awarded
February 20	March Board Meeting
May 20	June Board Meeting
August 20	September Board Meeting
November 20	December Board Meeting

If this application is an emergency and requires review prior to Nakon Foundation quarterly meetings, please mark the box below and include shut-off, eviction or foreclosure notice or other reference to emergency need. Be sure to include explanation of the emergency need on page 4, Needs Assessment

YES, PLEASE CONSIDER THIS APPLICATION FOR EMERGENCY FUNDING

EMERGENCY REVIEW: DATE REC _____

ACTION _____

Return Application and REQUIRED Pathology Report to:

The Karen P. Nakon Breast Cancer Foundation
 35765 Chester Road
 Avon, OH 44011
 info@nakonfoundation.org
 440-933-7621

Applicant's Full Name: _____

Permanent Address: _____

City: _____ County: _____ State: _____ Zip: _____

Current Address if different than above: _____

City: _____ County: _____ State: _____ Zip: _____

Phone- Home: _____ Cell: _____ Work: _____

Email address: _____

DOB: _____ Age: _____ Race (optional): _____

Marital Status: Single Married Widowed
 Separated Divorced Living with partner

Spouse/Partner's Full Name: _____

Children and/or dependents and their relationship to you:	Resides with you?
Name: _____ Age: _____ Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PT
Name: _____ Age: _____ Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PT
Name: _____ Age: _____ Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PT
Name: _____ Age: _____ Relationship: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> PT

Medical Information

Please attach a copy of your complete pathology report and treatment summary for verification purposes.

Application cannot be reviewed without this information.

Pathology Report Enclosed: Yes No

Treatment Summary Enclosed Yes No

Physician's Name: _____ Facility: _____ Phone: _____

Social Worker's Name: _____ Facility: _____ Phone: _____

Social Worker's Email: _____

Social Worker Notes (if applicable): _____

Referred by: _____

Insurance and Prescription Information:

Type of Health Insurance (Please check all that apply):

- Private health insurance provider (Medical Mutual, Kaiser, etc.)
- Medicare plus Medicaid Medicaid Medicaid Pending
- Medicare plus other supplemental coverage Cobra
- Public Health Insurance Charity Care
- Disability VA Program None
- Other: _____

Are your prescription drugs covered? Yes No

Additional Aid and Assistance:

Have you received assistance from the Nakon Foundation in the past? Yes No

If Yes, Date: _____ Amount: _____ Purpose: _____

Have you received assistance from any other cancer foundation? Yes No

If Yes, what is the name of the Foundation? _____

Date: _____ Amount: _____ Purpose: _____

Do you currently have an application for assistance pending with another foundation? Yes No

If Yes, what is the name of the Foundation? _____

Income and Employment Status

Applicant's current employer: _____

Occupation: _____

Status: Full-time Part-time FMLA Unemployed
 Retired Disability Other (please explain): _____

Current monthly gross income: \$ _____

From (please check all that apply): Paycheck Pension Social Security Disability
 Unemployment Alimony Food Stamps Other (please explain): _____

If currently unemployed, ***please identify previous employer and term of employment and/or explain employment history***
(ex: stay-at-home mom, laid off in 2010, unable to work because): _____

Spouse/Partner's current employer: _____

Occupation: _____

Status: Full-time Part-time FMLA Unemployed
 Retired Disability Other (please explain): _____

Current monthly gross income: \$ _____

From (please check all that apply): Paycheck Pension Social Security Disability
 Alimony Food Stamps Other (please explain): _____

Additional Person's Employed in the Household's current employer: _____

Occupation: _____

Status: Full-time Part-time FMLA Unemployed
 Retired Disability Other (please explain): _____

Current monthly gross income: \$ _____

From (please check all that apply): Paycheck Pension Social Security Disability
 Alimony Food Stamps Other (please explain): _____

Total Gross Monthly Income (from above): \$ _____

Public or Private Financial Assistance you are receiving: \$ _____

TOTAL HOUSEHOLD INCOME: \$ _____

Financial Statement and Needs Assessment

Assets:

Total Cash and Non-Retirement Bank Accounts (checking, savings, cds, etc):\$ _____

Retirement Accounts (include IRA, 401(k), 403(b), pensions and profit sharing)..... \$ _____

Investments (stocks, bonds, mutual funds, brokerage accounts, etc.)..... \$ _____

Real Estate: Value of Residence \$ _____

Value of Rental Property/Vacation Property..... \$ _____

Automobiles:..... \$ _____

Total Assets:..... \$ _____

Debts:

	Monthly Payment	Balance
Mortgage (for your home, excluding taxes and insurance).....	\$ _____	\$ _____
Real Estate Taxes.....	\$ _____	\$ _____
Rent.....	\$ _____	\$ _____
Other loans (personal, home equity, lines of credit).....	\$ _____	\$ _____
Student Loans.....	\$ _____	\$ _____
Auto Loans.....	\$ _____	\$ _____
Credit Card Debt.....	\$ _____	\$ _____
Monthly Utilities (gas, electric, phone, water, sewer, etc.).....	\$ _____	\$ _____
Food	\$ _____	\$ _____
Medical Expenses	\$ _____	\$ _____
Other Debts and Monthly Expenses	\$ _____	\$ _____
Total Debt:.....	\$ _____	\$ _____

Amount that you are requesting \$ _____

Purpose: _____

I understand that the Nakon Foundation will rely upon the truth and accuracy of the above.

If this application is not completely filled out or does not include a pathology report with course of treatment, the application will not be accepted nor considered for assistance.

Applicant Signature: _____ Date: _____



Publicity Release

The Karen P. Nakon Breast Cancer Foundation holds events and fundraisers throughout the year to raise money to fund the grants to help families endure the staggering costs of breast cancer treatments. We could use your help to put a face and a name to this cause.

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 reporting to the community on the work that is being done and in turn assist in our fund raising efforts. Please indicate your permission and/or interests by checking the appropriate areas:

- Use of photo
- Use of your background information
- Use of your First Name
- Use of your First AND Last Name
- Willing to be contacted to speak at fundraising events on behalf of the Foundation
- NO, I prefer to remain anonymous.

I understand this will not in any way exclude me from receiving assistance.

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, annual reports, newsletters, website and brochures..

Signature of Applicant

Date



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: _____ Last 4 digits of SSN: _____

I hereby authorize _____
(Health Care Provider)

to release all pathology reports, copies of charts and medical information regarding my treatment plan to The Karen P. Nakon Breast Cancer Foundation at 35765 Chester Road, Avon, OH 44011.

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 records to any outside source without first obtaining your prior express consent.

Signature of Applicant Date