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.

- Applicants must reside within the following Northern Ohio counties: Allen, Ashland, Ashtabula, Auglaze, Belmont, Carroll, Crawford, Columbiana, Coshocton, Cuyahoga, Defiance, Erie, Fulton,Geaugua, Hancock, Hardin, Harrison, Henry, Holmes, Huron, Jefferson, Lake,Logan, Lorain, Lucas, Mahoning, Medina, Mercer, Monroe, Ottawa,Paulding, Portage, Putnam, Richland, Sandusky, Seneca,Shelby, Stark, Summit, Trumbull, Tuscarawas, Van Wert, Wayne, Williams, Wood,

- Applicants are only eligible for assistance once in a calendar year (12 months).

- 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.

- Please do not staple the application components and do not use the backs of any pages.

- 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.

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

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

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

Return Application and REQUIRED Pathology Report to:
The Karen P. Nakon Breast Cancer Foundation
35765 Chester Road
Avon , OH 44011
info@nakonfoundation.org

Emergency applications for review outside of the Nakon Foundation quarterly meetings must demonstrate an immediate needthe emergency by including copies of any bills, legal notices, estimates, etc.

Please indicate the type of emergency and paperwork included with the application:

- ☐ Eviction / Foreclosure - Paperwork included:_____
- ☐ Utility shut off or disconnect—Paperwork included:_____
- ☐ Other (please explain) - _____

_____

Applicant's Full Name:_____

Permanent Address:_____

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

Current Address if different than above:_____

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

Applicant 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:_____ ☐ Yes ☐ No ☐ PT

Name:_____ Age:_____ Relationship:_____ ☐ Yes ☐ No ☐ PT

Name:_____ Age:_____ Relationship:_____ ☐ Yes ☐ No ☐ PT

Name: _____ Age:_____ Relationship:_____ ☐ Yes ☐ No ☐ 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: $_____

Biography/Needs Assessment

This section provides an opportunity to share your story, specifically how cancer has impacted you financially. Please use the space below to indicate your specific circumstances (duration of your cancer, immediate needs you have, special work/income limitations, etc.). If financial information indicated that your current income exceeds your expenses, please explain circumstances.

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