The Susan D. Crum Foundation

Dear Breast Cancer Survivor:

On behalf of the Board of Directors, thank you for reaching out to The Susan D. Crum Foundation (TSDCF) to request a financial assistance award. No matter where you are on your journey, I encourage you to lean into God . . . move toward God. He can take your anger, confusion, sadness and fear. Be honest with Him. He wants your whole heart. Let Him help you, comfort you, provide for you. And let others pray for you. God is able to bring good out of something as awful as cancer. As much as I hate cancer, I want you to know from my experience God used cancer to expand my heart. I have met some of the most remarkable people on this journey. I have been blessed in immeasurable ways by the thoughtfulness and generosity of so many. That is why I want to give back to help others. Besides, I am not the same woman today because of cancer . . . I am more. Cancer has marked my life, but it does not define my life.

In regards to this application, please complete the patient sections on pages one and two and ask your oncology doctor, nurse or social worker to complete the medical information section on page three. Patients or family members *cannot* complete the medical information section of the form (page three). Applicants must meet financial eligibility criteria and provide proof of income as follows:

- Copies of the first two pages of your signed income tax return. (You may blacken out your social security number).
- If you do not file a tax return, you may provide copies of your most recent pay stub, unemployment check, or SSI, SSD, or public assistance benefit notification.
- If you do not have income please provide a letter of support from a friend or family member.

Please return this form and the requested documents at your earliest convenience. Our funds for financial assistance are limited and based on availability and completing this application is not a guarantee of acceptance. Please be thorough as all sections of the application must be completed in order for your application to be considered. We will keep your application on file for six months.

Your completed form can be mailed to The Susan D. Crum Foundation, 615 W. Main Street, Greeneville, TN 37743. If you have any questions about this form or need assistance in completing it, please call our office at 423-470-2297. All information is strictly confidential and for TSDCF use only.

I am praying for God's blessing on your life in unexpected ways.

Love from a fellow warrior in pink,

Susan

Susan D. Crum, President and Two-Year Breast Cancer Survivor
The Susan D. Crum Foundation

THE SUSAN D. CRUM FOUNDATION

APPLICATION FOR “STILL SPARKLING IN PINK” AWARD

Please note incomplete applications cannot be accepted.

PATIENT INFORMATION (Please print clearly):

First name ________________________ Last name ________________________ Today’s date _________

Address ____ City, State, Zip ________________________

Phone number: Home ( ) ____________________ Work ( ) _________________ Cell ( ) _______________

Email Address ____ Date of birth _____________

Number of children at home ____ Other dependents ___________ Name of spouse ________________

If patient is a minor (under 18), name of parent or guardian: _____________________________________

□ Male □ Female Ethnicity: □ White □ African American □ Latino □ Asian □ Other _____________

APPLICANT'S NAME: ___________________________________ DOB: ______________________

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? □ Yes □ No

If yes, please indicate type of insurance (check all that apply):

□ Private insurance □ Medicaid □ Medicare □ Medicare plus Medigap □ Other ______________

Are prescription drugs covered? □ Yes □ No

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? □ Yes □ No Number of people in household: _________________

FAMILY INCOME SOURCES (please check all that apply):

□ Social Security (retirement) □ Salary □ Pension □Unemployment □ Public assistance

□ Short-term disability □ SSD (Disability) □ SSI

□ Family/friends provide support □ Other - specify _____________________________________

Acceptable proof of income:

- First two pages of signed copy of income tax return (you may blacken social security number)
- If you do not file a tax return: Copies of most recent pay check, unemployment check, SSI, SSD, public assistance benefit notification

TOTAL ANNUAL FAMILY INCOME **: ______________ **
Application will not be processed if this information is not provided**

Please be aware funds are limited, and based on availability as well as on meeting TSDCF eligibility requirements. TSDCF pays to invoice only, cash is not provided.

Amount Requested: $___________ (TSDCF does not pay medical, phone, cable, pharmacy bills or credit cards.)

FINANCIAL ASSISTANCE NEEDS (Check all that apply):
I need help with the following cancer-related expenses: □ Transportation □ Child care □ Home care
□ Lymphedema Supplies □ Other ____

Signature: ______________________________________ Date: ________________________________
Relationship to person applying for help:
□Self □ Spouse □ Family member/caregiver □Health care professional

I ATTEST BY WAY OF MY SIGNATURE THAT ANY FINANCIAL ASSISTANCE GRANTS WHICH MAY BE AWARDED WILL BE UTILIZED FOR THE EXPENSES INDICATED ABOVE

Name of person completing this section (please print): ____

TSDCF will review this information and contact the person requesting financial assistance. All information is strictly confidential and is for TSDCF use only.

MEDICAL INFORMATION

*** THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGY NURSE, DOCTOR, SOCIAL WORKER OR PATIENT NAVIGATOR ONLY ***

Date of diagnosis _________________ Current Stage ________________ □ New diagnosis □ Recurrence

Is patient in active treatment? □ Yes □ No
If no, indicate frequency of follow-up: □ Yearly □ Six months □ Other_____________________________

Please indicate type of treatment(s) received in past twelve months (check all that apply):
□ Chemotherapy □ Radiation □ Surgery □ Hormonal □ Palliative care □ Other ______________________

HEALTH CARE PROFESSIONAL INFORMATION:

(Please print): MD name ______________________________ Hospital/Clinic ______________________
Address ___________________________________ City, State, Zip ______________________________
Phone: ______________________________________ Fax ____________________________________

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):
____

Phone: ____________________________ Email: ____

Your relationship to person applying for help: □ Doctor □ Nurse □ Social Worker □ Patient Navigator

Signature of MEDICAL Professional: ____ Date___________

***** PLEASE COMPLETE ALL FIELDS ABOVE*****

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