

**Application Directions and Checklist**  
**Please Read Carefully**

Please be sure to provide all the information requested here.  
An incomplete application will delay our ability to provide you with assistance.  
Please call us at (305)255-1385 if you have questions or  
would like help completing the application.

**FOLLOW STEPS 1 – 6 TO COMPLETE THE**  
**Sandy B. Muller Breast Cancer Foundation Application**

**Step 1: Read “Criteria for Applicant Review and Selection”.**

**Step 2: Read the “Application Directions” carefully and thoroughly (this page).**

**Step 3: Explore other financial resources.**

Because the Sandy B. Muller Breast Cancer Foundation will be unable to provide all the financial help you may need, you will want to explore and apply for assistance from other financial resources that might be able to help you.

**Step 4: Fill out the Sandy B. Muller Breast Cancer Foundation Application completely and accurately (pages 1-4).**

**Step 5: Prepare the required attachments listed below in A and B.**

- A. Proof that you live in Miami-Dade County, Florida – Submit a copy of your current Florida Driver’s License or I.D. with an address matching your application. If you do not have a Florida-issued license or I.D., you can submit a rental contract or mortgage bill with your name on it; if these are in a spouse’s, partner’s or family member’s name, please explain.
- B. Medical status verification – Submit a signed letter from your oncologist on letterhead verifying your current diagnosis and treatment plan.

**Step 6: Read and check the boxes to verify the following information:**

- I understand the Sandy B. Muller Breast Cancer Foundation does not pay for medical expenses of any kind.
- I live in Miami-Dade County, Florida.
- I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy/cancer-related surgery and/or I am undergoing chemotherapy, radiation therapy, or gene therapy.
- I have signed the bottom of page 4 of the application which serves as a medical release, giving the Sandy B. Muller Breast Cancer Foundation permission to obtain the necessary medical information to process my application.
- I understand that the Sandy B. Muller Breast Cancer Foundation will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone interview.

**Mail your completed application and all required attachments to:**  
**Sandy B. Muller Breast Cancer Foundation**  
**P.O. Box 565371**  
**Miami, FL 33256**

# Sandy B. Muller Breast Cancer Foundation

## Personal Information

Patient's Name \_\_\_\_\_ Male  Female

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Best number to reach you? Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ Best time to call \_\_\_\_\_

Additional contact person that we may discuss your application with, if we can't reach you:

\_\_\_\_\_  
\_\_\_\_\_

Marital status: Single  Married  Other (please state) \_\_\_\_\_

No. of dependents: \_\_\_\_\_ No. of wage earners in home: \_\_\_\_\_ Total No. in household: \_\_\_\_\_

Language(s) spoken: English  Spanish  Other Language(s) \_\_\_\_\_

Health insurance: None  Medicaid  Medicare  Private  Other \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Monthly premium \_\_\_\_\_

Insurance provided through: My employment  Spouse's employment  Other \_\_\_\_\_

Employment status *before* your breast cancer diagnosis:

Full-time  Part-time  On leave  Self-employed  Retired  Unemployed

Employment status *after* your breast cancer diagnosis:

Full-time  Part-time  On leave  Self-employed  Retired  Unemployed

When did you last work: \_\_\_\_\_

Name: \_\_\_\_\_

## Sandy B. Muller Breast Cancer Foundation

### Financial Information – Income

#### Income – Entire Household

Please enter current income (in whole dollars) from all household sources in the blanks below:

	<u>Monthly Income</u>	<u>Non-Recurring Gift or Assistance</u>
Your gross wages (before taxes or deductions) Employer's name & address: _____ _____ _____	\$ _____	\$ _____
Spouse or partner's gross wages (before taxes or deductions) Employer's name & address: _____ _____	_____	_____
Sick Leave Pay	_____	_____
Employer Disability Insurance	_____	_____
Unemployment Insurance	_____	_____
Retirement/Pension	_____	_____
401(k) / IRA income	_____	_____
Social Security	_____	_____
SSI / SSDI	_____	_____
Old Age Pension (OAP)	_____	_____
Alimony/Child Support Received	_____	_____
Other Investment Income	_____	_____
Food Stamps	_____	_____
Section 8 from HUD (housing supplement)	_____	_____
Help from family members	_____	_____
Help from religious/faith community	_____	_____
Help from friends	_____	_____
Help from other nonprofit organizations	_____	_____
All Other: _____ _____	_____	_____
<b>TOTAL CURRENT MONTHLY INCOME:</b>	<b>\$ _____</b>	

<u>ASSETS</u>	<u>Value</u>	<u>Monthly Income From (Int., Div., Life Ins.)</u>
Cash/Checking	\$ _____	\$ _____
Savings	_____	_____
Real Estate – Personal Residence Value	_____	_____
Real Estate (not the house you live in) Value	_____	_____
Life Insurance	_____	_____
Investments (Stocks, bonds, etc.)	_____	_____
Retirement Funds	_____	_____
Other: _____ _____	_____	_____

Name: \_\_\_\_\_

## Sandy B. Muller Breast Cancer Foundation

### Financial Information – Expenses

#### Expenses – Household

Please enter monthly expenses for your entire household in the blanks below:

	<u>Monthly Expense</u>	<u>Occasional or One-Time Expense (please specify)</u>
Fed/State/FICA/Medicare Employment Taxes	\$ _____	\$ _____
Other payroll deductions	_____	_____
Rent	_____	_____
Mortgage	_____	_____
Food	_____	_____
Utilities	_____	_____
Child care	_____	_____
Child support paid	_____	_____
TV/Internet/Cable/Satellite	_____	_____
Telephone/cell including long distance	_____	_____
Car payment	_____	_____
Gasoline	_____	_____
Car insurance	_____	_____
Health insurance premium	_____	_____
Medical costs (after insurance)	_____	_____
Medication costs (after insurance)	_____	_____
Life insurance	_____	_____
Loan payments	_____	_____
Credit card payments	_____	_____
Household costs	_____	_____
Other: _____	_____	_____
Other: _____	_____	_____
Other: _____	_____	_____
Other: _____	_____	_____
<b>TOTAL MONTHLY EXPENSES:</b>	<b>\$ _____</b>	

Have you sought creditor relief for any of the bills you itemized above? If so, describe in detail what you have requested, what has been approved, and what is pending.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

## Sandy B. Muller Breast Cancer Foundation

### Medical Information Breast Cancer History

Current Diagnosis

Date Diagnosed: \_\_\_\_\_ Stage: \_\_\_\_\_ Type (if known): \_\_\_\_\_

Surgery:

Lumpectomy Date: \_\_\_\_\_

Mastectomy Date: \_\_\_\_\_

Sentinel Node Biopsy Date: \_\_\_\_\_

Axillary Dissection Date: \_\_\_\_\_

**Chemotherapy:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Radiation:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Gene Therapy:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Other therapy or treatment details:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you being treated for a recurrence?  Yes  No

Please fill out the contact information below:

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Oncologist: \_\_\_\_\_

Radiation Oncologist: \_\_\_\_\_

Social Worker/Case Manager: \_\_\_\_\_

Other: \_\_\_\_\_

I understand that the Sandy B. Muller Breast Cancer Foundation provides services that are free and that all awards are made at the sole discretion of the Sandy B. Muller Breast Cancer Foundation. The information provided in this application is true. I release Sandy B. Muller Breast Cancer Foundation of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize Sandy B. Muller Breast Cancer Foundation to release any information including my name, address, and type of assistance provided to any other social service or government agency at its discretion. I also authorize the release of any medical information and documentation required by Sandy B. Muller Breast Cancer Foundation for the purpose of verifying this application and I agree to sign any additional authorizations that may be required.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_