Patient Sponsorship Application:

Friends Thru The Fight assists with financial needs for patients actively receiving breast or gynecological cancer treatments. It is supported through the fundraising efforts of its members and donations.

A few things you should know:

1. FTTF Application Committee typically reviews submitted applications on the second Friday of every month.
2. To allow enough time to review, process and copy your application, the FTTF Committee **must** have it by the end of the business day the first Friday of every month. Late applications will be treated as LATE and will be reviewed at the following month.
3. Please note that Galveston County residents are given priority but other local county residence (Harris, Fort Bend, Brazoria, Chambers, Waller) may also apply.
4. Patients must be in active breast or gynecology cancer treatment (**within the last 30 days)** to be eligible to apply for assistance.
5. The committee will accept only one application per patient each month.
6. Please ensure the entire application form is completed. Incomplete forms will not be considered.
7. Each request will be reviewed individually.
8. The amount of assistance granted will depend on the amount of funds available and the limits set by the board.
9. Submitting an application does not guarantee funds or services.
10. The information you provide on your application is kept in the strictest confidence. Please allow us the same courtesy regards to the amount of funds provided to you (do not share with others how much you received).

PHYSICIAN Certification Form- must be filled out completely and must be updated once the treatment duration has expired or if the patient's residency status changes. FTTF reserves the right to request an updated Physician Cert Form at anytime.

***** INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED*****

FTTF APPLICATIONS MUST BE RECEIVED BY THE 1ST FRIDAY OF EACH MONTH FOR CONSIDERATION FOR THE FOLLOWING MONTH.

Original Applications Each Month ONLY (all pages must be original- no copies)- *please do not resubmit previous month's applications.*

Today's Date: _________________

Applicant/ Patient's Name:______________________________Age_______ Date of Birth___________
Applicant's phone number (____)__________________Do you respond to text messages?___________
Email:_________________________
Applicants Address:_____________________________
City_____________________State______Zip__________

Are you receiving support from other community or other nonprofit/charity organizations *(such as Susan B. Komen, Sisters Helping Sisters etc)?* If so, please include name and type of support:
____

Diagnosis & condition (list all medical conditions):
____

____

Number living in household:_____________
Ages of dependent children in household_______________
Others financially dependent on applicant:___________________
Is patient current:
Employed: ___Full time ___Part Time___employed but on FMLA/ Disability/ Leave

If unemployed, please list last date & place of employment: _________________________

	APPLICANT	**SPOUSE**	**OTHER PERSON**
Employer	_________________	______________	______________
Type of work	_________________	______________	______________

Current Estimated Household Income:__________________________
Current Estimated Financial Needs:_____________________
Current Estimated Expenses:______________________

How did you hear about our program: _______________________________________

2021 updated JS

Please list your top three needs in order of importance (example: meal calendar set up, gift card, spiritual guidance/support, financial support, etc)

1. ______________________
2. ______________________
3. ______________________

Do you or your families members have any food allergies or restrictions (if yes please describe)?:____

Do you have a religious preference? _______________________________________

Would you like to be added to the FTTF Fighter page on Facebook? (it is a private group of local women within our organization?)   Yes/ No   If so, please share your FB name so we can add you.____________

What else would you like to share about yourself?:
____
____
____

By my signature below, I (applicant) certify that all information provided is complete and accurate to the best of my knowledge. I understand that Friends Thru The Fight, Inc (FTTF) is not required to render any assistance to me and that I will remain responsible for payment of all my bills. By accepting this application, FTTF has NO responsibility for payment of any bills.

By my signature below, I (applicant) am aware that if I am accepted into the FTTF sponsorship program, any funds distributed by FTTF to me are intended to be used to assist with rent/mortgage, childcare and/or utilities per FTTF guidelines for sponsorship. I acknowledge that I will use for these purposes only.

_________________________________	_____________________________	________________
Applicant's Name (Print)	Applicant's Signature	Date

**** All information must be complete for application to be processed****
**** Only patients currently undergoing active breast or gyn cancer treatment will be considered for assistance. Active treatment is considered treatment directly related to breast/gyn cancer and consists of- IV chemo, radiation, surgery (up to 6 weeks post op).*
**** PHYSICIAN CERTIFICATION FORM MUST accompany this application for application to be considered.*
**** We reserve the right to decline or discontinue services if there is abuse of the services rendered.*

Please return application to:

Friends Thru The Fight, Inc
Po Box #666
League City, TX 77574
Or email to: friendsthruthefight@gmail.com

Friends Thru The Fight
Patient Authorization Form

I hereby authorize the physician(s) or physician groups noted below to verify my status as a cancer patient, discuss my diagnosis and review the anticipated duration of my treatment plan with the representatives of the Friends Thru The Fight, Inc. **Patient please allow your physician/provider to keep a copy of this authorization for their records so we may contact them.

Patient Name:__________________________ Date of Birth:________________
Address: _______________________________ Email:___________________________
Home Phone: _____________________________Work Phone______________________

Physician Name: ____
****Email of physician or contact person at clinic (required):*** ______________________
Physician Office Address: ____
Physician Office Telephone Number:_______________________________
Physician Office Fax:________________________________

Patient Signature: ______________________________ Date:_____________

Physician Certification

I (physician/provider) certify that_______________________(patient name) is being actively treated for______________________(breast/gyn cancer-related diagnosis).

Treatment Type: (please check all that apply)

______IV chemotherapy - Chemo Drug name:___________- Frequency & Duration:________

______Oral chemotherapy -Chemo Drug Name:__________ Frequency & Duration:________

______Surgery date:____________

______Radiation- Frequency & Duration of Radiation:___________

Treatment began on ___________________(date) and the patient is expected to be under treatment for______________________(time frame). (Hormone suppressant therapy not included)

Applications without firm dates will not be considered.

______________________________ ______________________________ ____________

Physician Print Physician Signature Date

(**must be physician signature**—cannot be stamped or nurse signature)

Please return email this form to: friendsthruthefight@gmail.com or the address above.