Go Jen Go

Application for Patient Assistance

First Name: _____ **Last Name:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

Age: _____ **Number of Children (living in the home):** _____

Race/Ethnicity (*Optional):*

☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander
☐ African American ☐ White/Caucasian ☐ Mixed Race ☐ Prefer not to answer

Marital Status *(Optional)*: _____

Date of Breast Cancer Diagnosis: _____

Breast Cancer Type/Subtype: _____

Current Stage: _____ **Name of Oncologist:** _____

Are you currently undergoing active treatment?

○ Yes ○ No

Please describe your treatment plan (surgery, chemotherapy, and/or radiation):

_____

_____

Length of treatment (include specific dates and/or estimated timeframe):

_____

_____

Treatment Facility: _____

Insurance Provider: _____

Current Yearly Household Income (include spouse/partner earnings): _____

Employment Status

○ Full Time ○ Part Time ○ Unemployed ○ Retired ○ Disabled

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If not currently working, describe reason: *Select all that apply*

☐ Treatment schedule prohibits working ☐ Recovering from treatment ☐ FMLA

☐ Receiving Short Term Disability ☐ Receiving Long Term Disability ☐ Retired ☐ Disabled

☐ Other (please describe) _____

Employer: _____

Are you working with a Social Worker or Patient Navigator?

○ Yes ○ No **List Name:** _____

May we contact your Social Worker or Patient Navigator on your behalf?

○ Yes ○ No **List Email:** _____

How did you hear about Go Jen Go?

☐ Hospital/Healthcare Provider ☐ Go Jen Go Website ☐ Family/Friends ☐ Another Patient

☐ Event ☐ Social Media ☐ Other (please describe) _____

Please select the form of assistance most helpful in your current circumstances (*Select one):*

○ Monthly Stipend ○ Single Allocation of Funds

What is your Primary financial need right now (*Select one):*

○ Mortgage/Rent ○ Utilities ○ Transportation ○ Groceries/Necessities

Please describe your request for assistance in detail and outline your need: (include amounts of any past due bills) **Use additional page if needed*

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please include documentation of diagnosis and/or treatment plan from your healthcare provider *required for application to be complete

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I, _____, hereby attest that the information provided in this application is true, accurate, and complete and that I am the person who is the subject of the application or have been authorized to act on behalf of the applicant.

Signature: _____ Date: _____

If not patient, list your full name: _____

Relationship to Patient:

- ○ Parent or Guardian
- ○ Spouse or Partner
- ○ Family Member
- ○ Social Worker
- ○ Patient Navigator
- ○ Healthcare Provider
- ○ Other

Applications for assistance are reviewed twice a month. You will receive an update or request for additional information typically within 3 weeks of your application submission. Questions can be directed to meredith@gojengo.org.