

# SOLANO MIDNIGHT SUN FOUNDATION

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

## CLIENT APPLICATION FORM

Candidates for financial assistance must have been diagnosed with breast cancer, and must have a treatment plan and be pursuing that treatment plan or recovering within 2 months of the end of the treatment plan. If you have a diagnosis of metastatic breast cancer, are undergoing any form of treatment, and the disease or treatment prevents you from working, you may be considered eligible for assistance.

If you have completed surgery, chemotherapy, and/or radiation for primary breast cancer, are considered to have no evidence of disease (NED), and are now taking adjuvant Tamoxifen, Arimidex or similar hormonal treatment on a long-term basis, you are no longer considered to be in treatment for active breast cancer and are no longer eligible for assistance. If you stop treatment for any reason against your oncologist's advice, you will no longer be eligible for assistance.

Thank you for applying to Solano Midnight Sun Foundation (SMSF). Please read the following instructions before beginning the application.

1. Complete pages 2-5 of the application. Be as specific as possible with regard to income and expenses, savings, and other forms of assistance to which you may have access. Please initial the bottom of every page where indicated.
2. Pages 6 and 7 are two copies of an authorization for release of your medical information by your doctor. Fill this form out completely, and give one copy to your doctor (oncologist, surgeon - whomever you consider to be the head of your medical team). This form tells your doctor that you give him/her permission to provide information about you to SMSF and should be kept in your file. Please send one copy to SMSF along with your application.
3. Have your physician complete page 7, which will tell SMSF about your breast cancer diagnosis and treatment plan. He/she may complete the form and return it to you, or complete it and mail it directly to SMSF.
4. Submit your application to SMSF by mail or fax. Please note: Your application will not be processed until complete, including receipt of the physician report (page 7).

### CRITERIA FOR ELIGIBILITY

**SMSF provides support for individuals living in Solano County who are going through breast cancer treatment, and whose income and/or expenses are significantly impacted by treatment. SMSF reserves the right to verify income, expenses, and treatment plan by requesting the following information.**

VERIFICATION	CONDITIONS
<b>Identification</b>	Must provide proof of identification. Picture ID, CDL, California ID, passport, employment or school ID, or other acceptable identification and social security card.
<b>Housing</b>	Must be a resident of Solano County to be eligible for SMSF support. Proof of location of residence by rent receipt, mortgage payment receipt or contract, or note from landlord; utility receipts, turn-off notice, late notice, eviction notice, fore-closure notice, 3 day notice to quit, etc.
<b>Income</b>	Must provide verifiable income information for pre-treatment and during treatment. Earned and unearned income for spouse or other responsible persons living in the home.
<b>Medical statement</b>	Must be in active treatment to receive SMSF support. Current diagnosis, prognosis, surgery date, and treatment plan with date and signature of treating physician
<b>Non-shelter expenses</b>	Must provide information about credit payments, car payments, child care, child support, cable, furniture storage, health club, other legal obligations for spouse or other responsible persons living in the home
<b>Vehicles</b>	Exempt
<b>Personal Items</b>	Exempt
<b>Real estate</b>	Exempt

***\*\*Please initial the bottom of every page of this application\*\****

Date of Application \_\_\_\_\_

# SOLANO MIDNIGHT SUN FOUNDATION

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

Referred to the Solano Midnight Sun Foundation by: \_\_\_\_\_

## DEMOGRAPHIC INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Phone number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Ethnicity (optional): \_\_\_\_\_ Preferred Language: \_\_\_\_\_

### MARITAL STATUS (please circle)

1. Married	2. Never Married	3. Separated	4. Divorced
5. Widow(er)	6. Other _____		

IF MARRIED, HUSBAND'S NAME:	Age	Birth Date	Occupation	How Long Employed
<b>CHILDREN</b>				
<u>Name</u>	<u>Age</u>	<u>Birth Date</u>	<u>Gender (circle F or M)</u>	<u>Residence (circle Y or N)</u>
1.			F    M	Lives with you? Y / N
2.			F    M	Lives with you? Y / N
3.			F    M	Lives with you? Y / N
4.			F    M	Lives with you? Y / N
5.			F    M	Lives with you? Y / N
6.			F    M	Lives with you? Y / N
Other Dependents Living With You				
<u>Name</u>	<u>Age</u>	<u>Relationship to You</u>		
1.				
2.				
3.				
4.				

# ***SOLANO MIDNIGHT SUN FOUNDATION***

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

---

---

What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, etc.) \_\_\_\_\_

\_\_\_\_\_

Current breast cancer diagnosis – please include stage and treatment plan (in your own words) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tell us your reasons for making this application: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Did someone help you with this application?  No  Yes

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Please list your physicians below, including name and phone number:

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

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

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

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

Please provide us with an emergency contact. The person you list should be someone that you are in contact with on a regular (daily or weekly) basis that we can call if we are unable to reach you.

Name: \_\_\_\_\_ Relationship to you: \_\_\_\_\_

Home phone number: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Please use this space to add any comments or information you would like to tell us: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# SOLANO MIDNIGHT SUN FOUNDATION

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

## WORK HISTORY

Most recent employer: \_\_\_\_\_ Job title: \_\_\_\_\_

If not currently working, date last worked: \_\_\_\_\_ Monthly income when working: \_\_\_\_\_

<b>CURRENT INCOME</b>	<b>Monthly amount</b>
1. Your wages/salary <i>if you are currently working</i> (after taxes)	1. \$
2. Spouse/partner's wages/salary (after taxes)	2. \$
3. Property rental income	3. \$
4. Interest/dividends	4. \$
5. Veterans Benefits	5. \$
6. Roommate/Boarder	6. \$
7. Other	7. \$
<b>Please indicate if you have applied for any of the following.</b>	
<b>Circle "accepted" if you are receiving funding, "pending" if your application is in process, or "denied" if you have been denied for that program</b>	
8. Disability thru employer	Accepted Pending Denied 8. \$
9. State Disability Insurance	Accepted Pending Denied 9. \$
10. SSI/SSD	Accepted Pending Denied 10. \$
11. Other Soc. Sec. _____	Accepted Pending Denied 11. \$
12. Unemployment Insurance	Accepted Pending Denied 12. \$
13. Pension/Retirement	Accepted Pending Denied 13. \$
14. Worker's Comp	Accepted Pending Denied 14. \$
15. Child support/alimony	Accepted Pending Denied 15. \$
16. Care of foster child	Accepted Pending Denied 16. \$
17. In-home care/In-Home Supportive Services	Accepted Pending Denied 17. \$
18. School grants/loans	Accepted Pending Denied 18. \$
19. General Relief (Welfare)	Accepted Pending Denied 19. \$
20. Food Stamps	Accepted Pending Denied 20. \$
21. CalWORKS (AFDC)	Accepted Pending Denied 21. \$
22. Other _____	Accepted Pending Denied 22. \$
<b>TOTAL AVAILABLE MONTHLY INCOME (add lines 1-22 together):</b>	<b>\$</b>

# SOLANO MIDNIGHT SUN FOUNDATION

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

---

---

Are you receiving funds/loans/donations, etc. from any other social services agencies in your County?  No  Yes

If yes, list all agencies and dates and amounts of last aid (use a separate sheet if necessary):

---

---

## MONTHLY EXPENSES

1. <input type="checkbox"/> Mortgage or <input type="checkbox"/> Rent	1. \$
2. Gas	2. \$
3. Electricity	3. \$
4. Water	4. \$
5. Trash Collection	5. \$
6. Telephone and/or cellular phone	6. \$
7. Cable	7. \$
8. Food	8. \$
9. Auto Loan	9. \$
10. Auto Insurance	10. \$
11. Gasoline	11. \$
12. Medications (related to breast cancer treatment only)	12. \$
13. Medical co-payments and/or share of cost	13. \$
14. Health insurance premiums	14. \$
15. Other:	15. \$
16. Other:	16. \$
17. Other:	17. \$
<b>TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 17 together):</b>	<b>\$</b>

Please check this box if you would like to be referred to other agencies for possible assistance. Referrals may result in sharing your information between SMSF and other agencies.

By signing below, I agree that the above information is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

# **SOLANO MIDNIGHT SUN FOUNDATION**

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

---

---

To: \_\_\_\_\_  
Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, residing at \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization  
(20-8124921) specific information requested by them which I cannot provide concerning:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation (SMSF) I have read this form and have agreed to its request prior to my signing.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Birthplace

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Solano Midnight Sun Foundation.**

# ***SOLANO MIDNIGHT SUN FOUNDATION***

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

---

---

## **APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION**

To: \_\_\_\_\_  
Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, residing at \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

hereby authorize you to release to Solano Midnight Sun Foundation, non-profit organization  
(68-0354961) specific information requested by them which I cannot provide concerning:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is needed to determine my eligibility for assistance from Solano Midnight Sun Foundation  
(SMSF) .I have read this form and have agreed to its request prior to my signing.

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Birthplace

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Solano  
Midnight Sun Foundation.**

# SOLANO MIDNIGHT SUN FOUNDATION

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

## PHYSICIAN REPORT

The individual listed below has requested assistance from Solano Midnight Sun Foundation (SMSF) and has stated that s/he is unable to work or is unable to work at pre-treatment level. A signed release for the requested information is attached.

Please complete this form and return it by: \_\_\_\_\_ (date)

**Attn: Director of Client Services**  
**Solano Midnight Sun Foundation**  
**198 Dobbins St., Suite D**  
**Vacaville, CA 95699**  
**FAX: 707-450-0550**

SECTION I			
Name:			
Date of birth:		Social Security #:	
Physician's Name:		Physician's phone:	
Physician's Address:			
SECTION II – TO BE COMPLETED BY YOUR PHYSICIAN			
Diagnosis:			
Date of onset:		Date of last appointment:	
Pertinent pathology results (attach copy of report if available):			
Medications prescribed:			
Indicate client's prognosis:			
Specific physical limitations:			
Is patient's condition suitable for employment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
What level of employment activity is suitable for patient?		<input type="checkbox"/> Part-time _____ hours per week	<input type="checkbox"/> Full-time
Projected date patient can return to work at pre-treatment level:			
Planned surgeries – list date and expected date of recovery:			
Other planned treatments (chemo, radiation, etc.) – list projected end date:			
Comments:			
Physician's signature:		Date Signed:	

# ***SOLANO MIDNIGHT SUN FOUNDATION***

198 Dobbins Street, Suite D · Vacaville, CA 95688

phone: (707) 469-9909 fax: (707) 450-0550 website: <http://www.solanomidnightsun.org>

---

---