KOMEN FINANCIAL ASSISTANCE PROGRAM APPLICATION

THE KOMEN FINANCIAL ASSISTANCE PROGRAM (KFA) provides support to those struggling with expenses that often keep them from receiving the breast cancer care they need.

Program Overview

- We make every effort to process all completed applications within 6 weeks of receipt.
- All applications are processed in the order they were received.
- To reduce processing delays, please submit completed applications along with required medical letter at the same time and only once using one of the methods listed below.

Funding

- Funds may be used for daily-living costs such as rent, utilities, food, transportation, childcare, etc. (see full list on page 3).
- Funding payments may only be made directly to the applicant.
- Funding amount is based on current stage of breast cancer:

Stages 0-3	Stage 4
$500 is available for eligible individuals with earlier-stage breast cancer (Stages 0-3).	$750 is available for eligible individuals with stage 4 metastatic breast cancer, which is cancer that has spread to other parts of the body like bones, lungs, liver, or brain.

Eligibility Criteria

- Applicant must:
  - Currently be in treatment for stage 0-3 breast cancer that was diagnosed in the last 24 months OR living with stage 4 metastatic breast cancer.
  - Have a current annual household income at or below 300% FPL[1] (see page 3).
  - Live in the United States or a US Territory.
- Individuals may apply once per 12-months based on last payment date.

Instructions for Application

✓ Read carefully and complete the application.

✓ Get a letter* from the applicant's medical provider confirming:

- The applicant is currently being treated for breast cancer and
- Current stage of breast cancer (Stage 0-4).
- Date of current diagnosis.

*** Letter must be on official letterhead. For those living with stage 4 metastatic breast cancer, medical documentation confirming diagnosis may be submitted in place of a medical provider letter.**

✓ Submit completed application AND medical provider letter to one of the following:

Email: treatmentassistance@komen.org

Mail: ATTN: KFA,13770 Noel Road, Suite 801889 Dallas, TX 75380

Fax: 972-454-4657

https://aspe.hhs.gov/poverty-guidelines

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To ensure your application is not delayed: Please read the entire application carefully and make sure all required fields are filled out. Submit your completed application along with the required medical provider letter/information at the same time.

****Incomplete or unsigned applications will not be considered for funding****

APPLICANT INFORMATION

First name*: _____ Middle initial: _____ Last name*: _____

Address*: _____

Apartment/Unit #: _____

City*: _____ State*: _____ Zip code*: _____

Phone number*: Home _____ Cell _____

Email address: _____

Date of birth*: Month _____ Day _____ Year _____

Gender: ☐ Female ☐ Male ☐ Gender Diverse ☐ Prefer Not to Answer

Race: ☐ Asian or Asian American ☐ Black, African American, or African ☐ Hispanic, Latino, or Latina
☐ Indigenous American, Native American, or Alaska Native ☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Prefer Not to Answer
☐ Not Listed (please specify): _____

Preferred language for future communications: ☐ English ☐ Spanish

BREAST CANCER INFORMATION

Date of breast cancer diagnosis: _____

Breast cancer type: ☐ Ductal Carcinoma in Situ (DCIS) ☐ Invasive Ductal Carcinoma
☐ Invasive Lobular Carcinoma ☐ Inflammatory Breast Cancer ☐ Metaplastic Breast Cancer
☐ Other (please specify): _____

Breast cancer subtype: ☐ TNBC (ER-/PR-/HER2-) ☐ TPBC (ER+/PR+/HER2+) ☐ ER+/HER2-
☐ ER-/HER2+ ☐ Unknown ☐ Other (please specify):_____

Current stage*: ☐ Stage 0 ☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV ☐ Undesignated

**Required*

13770 Noel Rd., Suite 801889 Dallas, TX 75380 | 1-972-866-4233 | TreatmentAssistance@komen.org

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HEALTH INSURANCE INFORMATION

Please indicate type of insurance the applicant has. If applicant is uninsured select, 'Uninsured'.
(check all that apply): ☐ Private Insurance ☐ Medicaid ☐ Medicare ☐ Charity Care
☐ VA Program ☐ Medigap or Medicare Supplement ☐ Unknown ☐ Uninsured

HOUSEHOLD FINANCIAL INFORMATION

Employment status: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired

Family income sources (check all that apply): ☐ Salary ☐ Social Security ☐ Pension
☐ Retirement Savings ☐ Short or Long-term Disability ☐ SSD (Disability) ☐ Unemployment
☐ Family or Friend Support ☐ Other (please specify): _____

Number of people in household*: _____
Current total annual household income*†: _____

**Required. †Eligible applicants must have pre-tax household income at or below 300% of the Federal Poverty Line (FPL)*

Persons in Family/ Household	300% of the 2024 Federal Poverty Line (FPL)		
	48 Contiguous States and D.C.	Hawaii	Alaska
1	$45,180	$51,930	$56,430
2	$61,320	$70,500	$76,620
3	$77,460	$89,070	$96,810
4	$93,600	$107,640	$117,000
5	$109,740	$126,210	$137,190

FINANCIAL ASSISTANCE NEED

Please select your most urgent care related financial need (only select *ONE*): ☐ Transportation
☐ Rent or Housing ☐ Utilities or Bills ☐ Food or Groceries ☐ Lymphedema Supplies or Care
☐ Oral Treatment Medication (e.g. Chemotherapy, Hormone Therapy, etc.)
☐ Palliative Care ☐ Child Care ☐ Elder Care ☐ Home Health Care
☐ Side-effect Management Medication (e.g. Pain, Anti-nausea, etc.)
☐ Durable Medical Equipment (e.g. Oxygen Tank, Walker, etc.)

HOW DID YOU HEAR ABOUT THE KOMEN FINANCIAL ASSISTANCE PROGRAM?

☐ Hospital/Healthcare Provider (e.g. Doctor, Nurse, Patient Navigator, Social Worker)
☐ Internet/Radio/TV ☐ Komen Website ☐ Family/Friends/Another Individual with Breast Cancer
☐ Social Media ☐ Komen Breast Care Helpline (1-877-GO KOMEN)
☐ Other (please specify): _____

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PAYMENT INFORMATION

Direct deposit payments are more secure and received faster than a check.
Mailed checks will be mailed to the address listed on page 2 unless otherwise noted.
****Payments will ONLY be made to the applicant.****

Preferred method of payment: ☐ Direct Deposit ☐ Mailed Check
If direct deposit is preferred, please provide applicant's banking information below.

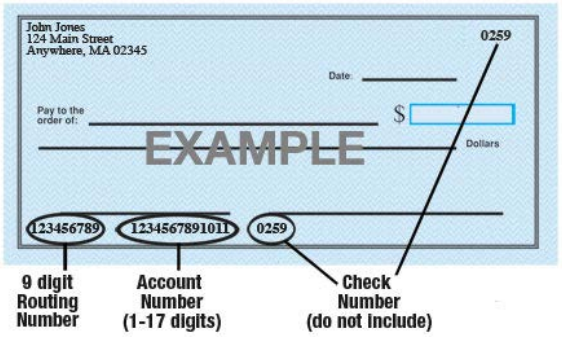
Account Type: ☐ Checking ☐ Savings

Bank Name: _____

Name on Account: _____

Routing Number: _____

Account Number: _____



Terms & Conditions

The data you provide herein will be used as set forth in Komen's Privacy Policy[2]. Komen, its employees and agents are hereby authorized to obtain and discuss medical, treatment, therapy, financial, and other information relating to applicant with the applicant's healthcare providers, pharmacy, employer, insurance company, and/or any other person or entity working with Komen on the applicant's behalf for purposes of confirming the applicant's eligibility for the Financial Assistance Program. Komen may also use or disclose the applicant's personal information as necessary for Komen to provide applicants with assistance under the program. Komen may anonymize and de-identify applicant information and data and use such information for Komen's own purposes, including to develop aggregate reports. Neither Komen nor any of its employees or agents will disclose any applicant identifiable information to any third party except as provided above, as required by law, or as deemed appropriate by Komen to investigate or resolve any potential fraud or audit irregularity.

Komen Financial Assistance Program continuation is dependent on the availability of funds, and Komen reserves the right to modify and/or discontinue the program at any time and without any prior notice to applicants. By submitting this application, the applicant agrees to hold Komen harmless for any losses that arise, either directly or indirectly, from the applicant's to, and participation in, the Komen Financial Assistance Program.

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 by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the Komen Financial Assistance Program. By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

Signature*: _____ Date*: _____

If not applicant: First name: _____ Last name: _____

Relationship to applicant: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member ☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider ☐ Other (please specify): _____

**Required*

[2]https://ww5.komen.org/AboutUs/PrivacyPolicy.html

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