BEYOND RESTORED, INCORPORATED

CLIENT'S APPLICATION

This organization was created with passion, and love. Its mission is to contribute to the eradication of breast cancer/cancer by providing compassionate care through advocacy and education awareness, daily basic needs to survivors, their family members and our communities.

To be considered for Assistance/Financial Assistance, please provide the following:

- ☐ **Completed Application**
- ☐ **Physician Verification Form- Signed**
- ☐ **Copy of Your Identification (Drivers License, State ID, Or Passport)**
- ☐ **Required Email Address: Must be provided to receive progress updates**
- ☐ **Copy of ONE Financial Obligation, i.e. utility bills**
- ☐ **Medical Accessories (Personal Needs, Compression Arm & Leg Sleeves etc.)**
- ☐ **Signed Terms and Conditions**

ASSISTANCE INCLUDES

- **Utility Bills (Gas, Water or Electric)**
- **Prescription Medications/Medical Accessories i.e. Compression Sleeves, Leg Sleeves etc.**
- **Transportation/Gas to Treatment Centers**

PLEASE CHECK AGAIN

INCOMPLETE APPLICATION PACKAGES WILL CAUSE DELAYS IN REQUESTS APPLICANTS MUST SUBMIT A COMPLETED ENTIRE APPLICATION PACKAGE TO BE CONSIDERED FOR ASSISTANCE

- ☑ Completed Application
- ☑ Completed Physician/Health Care Professional Form
- ☑ Copy of Your Identification (Drivers License, State ID, Or Passport)
- ☑ Required Email Address
- ☑ Copy of One Financial Obligation i.e. Utility Bill
- ☑ **Signed Terms and Conditions**

PLEASE MAIL APPLICATION & OTHER FORMS TO: Beyond Restored, Inc. P.O. Box 817793 Hollywood, Florida 33081-7793 Email to: beyondrestored@gmail.com -786-419-6828

Revised 3/31/2020

Office Use Only:

Date Rec'd: _____ Date Rec'd Assistance: _____

Beyond Restored, Incorporation Client's Official Application

If Approved, Payments are made directly to the Provider.

Submission of this application does not imply or guarantee approval of financial assistance.

CLIENTS CAN ONLY RECEIVE FUNDING ONCE A YEAR

Personal Information (Print Clearly)

Today's Date:		
First Name:		Last Name:
Date of birth (MM/DD/YYYY):	Phone:	Email:
Current address:		
City:	State:	Zip Code:
Medical Insurance: ☐ Yes ☐ No	If Yes: ☐ Private/Commercial ☐ County/State ☐ Medicaid ☐ Medicare ☐ Supplemental Insurance A ☐ Suppliemntal Insurance B Name of Insurance Carrier:	

RACE/ETHNICITY INFORMATION: (Check one)

☐ Black or African American
☐ American Indian or Alaska Native
☐ White
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Hispanic or Latino

ASSISTANCE REQUESTED (PLEASE SELECT ONE)

Please provide the below information to the support the bill you are submitting:

Have you received Beyond Restored, Inc. in the last 12 months? ☐ Yes ☐ No

What Type?
Amount Requested?

Utilities	FINANCIAL REQUEST	PROVIDER
Medical Bill	FINANCIAL REQUEST	PROVIDER
Rent	FINANCIAL REQUEST	PROVIDER
Mortgage	FINANCIAL REQUEST	PROVIDER

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Personal Information (Print Clearly)

FINANCIAL STATUS

Are you currently employed? ☐ Yes ☐ No	If **Yes**, please name occupation:
If **No**, state reason	
Annual Household Income ☐under $25K ☐ $25K-$49,999 ☐ $50K-$69K ☐ $70K+	
Head of Household ☐ Yes ☐ No	Number in Household:

List Sources of Income:

☐ Employment ☐ Child Support ☐ Public Assistance ☐ Family/friends provide support
☐ Social Security(Retirement) ☐ Pension ☐ Disability ☐ Unemployment

Education Level: ☐ Some School ☐GED ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post-Graduate

Physican Verfication Form - Beyond Restored, Inc. Breast Cancer/Cancer Assistance Program

Dear Oncologist/Physician:

Your patient has applied for financial/assistance from **Beyond Restored, Inc. Breast Cancer/ Cancer Assistance Program**) In order to complete the application process, the following information is to be verified by you as the ***prescribing and/or treating physician***. Please contact **Beyond Restored, Inc.** if you should have questions.

RELEASE OF MEDICAL INFORMATION

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name (print)_____

Patient Signature_____

PATIENT INFORMATION (PRINT CLEARLY)

Today's Date:		**Age of Diagnosis:**
First Name:		Last Name:
Date of birth: (mm/dd/yyyy)	Phone:	Email:
Current address:		
City:	State:	ZIP Code:

TYPE OF TREATMENT

Type of Breast/Cancer:	Current Stage of Breast/Cancer:
Currently in treatment? ☐ Yes ☐ No	**Treatment dates: Start:_____ Approximate Completion: _____**
Treatment:	

ONCOLOGIST CONTACT

Oncologist's Name:		Physician Stamp
Organization/Hospital:		
Address:		
City:	State:	ZIP Code:
Phone:	Fax:	Email:
Office Contact Name:	Position:	Phone (if different):

☐ I certify that the patient named is currently a patient and has been diagnosed with breast cancer and is currently under my care for treatment.

Health Care Oncologist's Signature: _____ Date: _____

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Terms and Conditions

Allocation of Funds: Beyond Restored, Incorporated Board of Directors allocates certain monies and other resources to the *Beyond Restored, Incorporation* through the annual budget. The number and size granted by the Breast Cancer/Cancer Program is dependent upon the allocation of Beyond Restored Inc. resource es to the Breast *Cancer/Cancer Assistance Program* within annual budget. Beyond Restored, Inc. Board of Directors has exclusive determination as to those monies and resources.

1. **Selection Process:** The application, including the selection of the successful applicant is reviewed by the Board of Directors or the Founder. the Board of Directors reserve the right to decline a request, and/or partially grant a request based upon the allocation of funds to the program. **REVIEWING OF THIS APPLICATION DOES NOT CONSITIUTE ANY PROMISE OR ASSURANCE BY SISTERS NETWORK (OR ANY OF ITS REPRESENTATIVES) TO AN APPLICANT REGARDING THE GRANTING OF THEIR REQUEST.**

2. **Grants of Rights, Restrictions on Use:** The information provided by applicant herein will only be utilized for Beyond® Restored, Inc. consideration of the Application. Your information will not be shared with anyone unaffiliated with Beyond Restored Inc. Should your request be granted, Beyond Restored, Inc. will not communicate with any third parties relating to your request without your prior consent. Beyond Restored, Inc. reserves the right to utilize your Breast *Cancer/Cancer Assistance Program* experience to share with potential sponsors as well as the general public in order to promote the Brest *Cancer/Cancer Assistance Program* to other women cancer survivors that could potentially participate in this program.
3. **Time Frame of Process:** The complete review /approval process takes approximately 24 hours from the date that Beyond Restored, Inc. received the entire application package.

I affirm that I have read the all of the above important information, and attest that the information provided by me in this application is true and correct to the best of my knowledge.

Applicant Signature: _____

Printed Name: _____ Date Signed: _____

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