Our goal is to give women tranquility and hope when faced with breast cancer

Please read carefully and be sure to provide all the information requested here. An incomplete application will delay our ability to provide you with assistance. If you have any questions or need help completing the application, please call us at (305) 546-7668.

FOLLOW STEPS 1 – 6 TO COMPLETE THE APPLICATION.

Step 1: Read the "Application Directions and Checklist" (this page). (Page 1)

Step 2: Read "Criteria for Applicant Review and Selection". (Page 2)

Step 3: Fill out the Badges of Courage Foundation Application completely and accurately (pgs. 3-6).

Step 4: Submit a copy of your most recent tax return (Form 1040).

Step 5: Prepare the required attachments listed below.

A. Proof that you live in Miami-Dade County, Florida – Submit a copy of your current Florida Driver's License or I.D. with an address matching your application. If you do not have a Florida-issued license or I.D., you can submit other proof of your residency in Miami-Dade County.

B. Medical status verification – Submit a signed letter from your oncologist on letterhead verifying your current diagnosis and treatment plan.

Step 6: **Read and check the boxes to verify the following information:**

☐ I understand the Badges of Courage Foundation does not pay for medical expenses of any kind.

☐ I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy/cancer-related surgery and/or I am undergoing chemotherapy, radiation therapy, or gene therapy.

☐ I have signed the bottom of page 6 of the application which serves as a medical release, giving the Badges of Courage Foundation permission to obtain the necessary medical information to process my application.

☐ I understand that the Badges of Courage Foundation will ask personal questions about my treatment and financial status. I agree to provide accurate answers on the application and in an interview.

Mail your completed application and all required attachments to:

Badges of Courage Foundation
3548 SW 25th St.
Miami, FL 33133

You may also email the scanned application and attachments to:
info@badgesofcourage.org

I. Residency and Treatment

Applicants must be residents of Miami-Dade county , Florida, and have been diagnosed with breast cancer and be within two months of breast cancer surgery (mastectomy, lumpectomy, auxiliary lymph node dissection or sentinel node biopsy) and/or currently undergoing chemotherapy, radiation therapy or gene therapy.

Additionally, an applicant may qualify for consideration based on combinations of the following financial criteria:

II. Income

Applicant's total household income at the time of application must be equal to or less than the median household income level for Miami-Dade County (based on the most recent year's statistics published by the State of Florida or Miami-Dade County, $38,100).

In addition, total household income from all sources (including wages, retirement, pension, alimony, worker's compensation, Social Security, disability insurance, etc.) does not meet the sum of all obligations for the applicant's determined treatment period.

III. Assets (we will consider the following)

A. Total liquid assets (cash, stocks, bonds, mutual funds, etc.) are less than the sum of all financial obligations for the determined treatment period.

B. Patient owns no secondary real property or other liquid real or personal property.

C. The actual value of your home does not generally exceed the median home prices for single family units sold in Miami-Dade County.

IV. Application Review

The Foundation will then conduct a review of each individual's financial situation to determine the greatest need. To this end, each applicant is asked to disclose and prioritize exactly what support they are asking for. The Foundation will interview the applicant, the applicant's physician and the applicant's social worker, if any, to understand the full scope of need. The Foundation will then determine what funding will be required to meet the applicant's most basic needs to survive the treatment period with as decent a quality of life as possible given their circumstances.

In summary, there are three steps involved with applications review. First, qualified applicants must demonstrate they are in the midst of treatment for breast cancer and must have need for financial support. Second, a patient must meet applicable income and asset guidelines. Third, the Foundation will conduct interviews with candidates for aid, their physicians and social workers, and other persons involved in patient's care.

Our goal is to give women tranquility and hope when faced with breast cancer

Personal Information

Patient's Name ____

Date of Birth ____________________ Social Security Number ____________________

Permanent Address ____

City ________________________ State_______________ Zip _______________

Best number to reach you? Home ____________Work ___________ Cell ___________

Best time to call ______

Is there a contact person that we may discuss your application with, if we can't reach you? If so, please provide a name, phone number and relationship:

____

____

How did you hear about the Badges of Courage Foundation?

____

Marital status: Single ☐ Married ☐ No. of dependents: _______

No. of wage earners in home: _________ Total No. in household: _________

Language(s) spoken: English ☐ Spanish ☐ Other Language(s)_______________________

Health insurance: None ☐ Medicaid ☐ (please submit copy of Medicaid card) Medicare ☐

Private ☐ Other_______________

Health Insurance Provider: ________________________ Monthly premium ___________

Insurance provided through: My employment ☐ Spouse's employment ☐ Other __________

Employment status before your breast cancer diagnosis:

Full-time ☐ Part-time ☐ On leave ☐ Self-employed ☐ Retired ☐ Unemployed ☐

Employment status after your breast cancer diagnosis:

Full-time☐ Part-time ☐ On leave ☐ Self-employed ☐ Retired ☐ Unemployed ☐

When did you last work (month/year): ______________________________________

Our goal is to give women tranquility and hope when faced with breast cancer

Please enter current income (in whole dollars) from all household sources in the blanks below:

MONTHLY INCOME

Take home wages: $ ______________
Employer's name, address & phone number:
____
____
____

Spouse or partner's take home wages: $ ______________
Employer's name, address and phone number:
____
____
____

Sick Leave Pay: ______________
Disability Insurance Benefits: ______________
Unemployment Benefits: ______________
Retirement/Pension: ______________
Alimony/Child Support Received: ______________
Investment Income: ______________
Food Stamps : ______________
Other: ______________________ ______________
____
____
____

TOTAL CURRENT MONTHLY INCOME: $ ______________

ASSETS

VALUE

Cash/Checking $ ______________
Savings ______________
Real Estate – Personal Residence Value ______________
Real Estate (not the house you live in) Value ______________
Life Insurance – Cash Value ______________
Investments (Stocks, bonds, etc.) ______________
Retirement Funds ______________
Other: ______________________ ______________

Our goal is to give women tranquility and hope when faced with breast cancer

Please enter monthly expenses for your entire household in the blanks below:

	MONTHLY EXPENSE
Rent:	______________
Mortgage:	______________
Food:	______________
Utilities (water, gas, electric):	______________
Child care:	______________
TV/Internet/Cable/Satellite:	______________
Telephone/cell including long distance:	______________
Car payment	______________
Gasoline	______________
Car insurance	______________
Other transportation expense	______________
Health insurance premium	______________
Medical costs (after insurance)	______________
Medication costs (after insurance)	______________
Loan payments	______________
Credit card payments	______________
Household expenses	______________
Other: ______________________________	______________
Other: ______________________________	______________
Other: ______________________________	______________
Other: ______________________________	______________

TOTAL MONTHLY EXPENSES: $ ______________

Please indicate the expenses that you are requesting assistance with (medical expenses not covered):

	EXPENSE
______________________________	$ ______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

TOTAL REQUESTED ASSISTANCE: $ ______________

Our goal is to give women tranquility and hope when faced with breast cancer

Current Diagnosis

Date Diagnosed: __________ Stage: ____________ Type (if known): ____________________________

Surgery:

- ☐ Lumpectomy Date: ____
- ☐ Mastectomy Date: ____
- ☐ Sentinel Node Biopsy Date: ____
- ☐ Axillary Dissection Date: ____

Chemotherapy: Start Date: _______________ End Date: ________________

Radiation: Start Date: ________________ End Date: ________________

Gene Therapy: Start Date: _______________ End Date: ________________

Other therapy or treatment details:

____

____

____

PLACE OF TREATMENT: ____

MEDICAL RECORD NUMBER:____

Are you being treated for a recurrence? ☐ Yes ☐ No

Please fill out the contact information below:

Name: **Location:** **Phone:**

Surgeon: ____

Oncologist: ____

Radiation Oncologist: ____

Social Worker/Counselor (if applicble):____

Other: ____

I understand that the Badges of Courage Foundation provides services that are free and that all awards are made at the sole discretion of the Badges of Courage Foundation. The information provided in this application is true. I release Badges of Courage Foundation of all liabilities or claims whatsoever arising out of the provision of financial assistance and/or services provided or otherwise. I authorize Badges of Courage Foundation to release my name, address, and type of assistance provided as required by law or to the Internal Revenue Service. I also authorize the release of any medical information and documentation required by Badges of Courage Foundation for the purpose of verifying this application and I agree to sign any additional authorizations that may be required.

Applicant's Signature: ___________________________________ Date ________________________

Print Name: ____