

SIS

1900 Empire Blvd. #239
Webster, NY 14580
Tel 585-362-0626
Fax 585-265-1917

Client Application Form



sustain inspire survive™
financial assistance for those battling breast cancer

www.helpsis.org

Personal Information

page 1

Name:	
Address:	
City:	
State:	
Zip code:	
Date of birth:	
Home phone:	
Work phone:	
Cell phone:	
E-Mail address:	
If someone has helped you complete this form, please provide name and contact information:	
Current breast cancer diagnosis including stage and treatment:	
Marital status:	<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) <input type="checkbox"/> Single <input type="checkbox"/> Single parent <input type="checkbox"/> Other _____
Number of children living at home and their ages:	
Most recent employment:	
If not currently working, date last worked:	
Date of onset:	
Diagnosis and staging	
Treatment plan/schedule include start date & projected end date	
Referred by or how you learned of SIS:	

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Monthly Expenses	page 3
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Mortgage/Rent:	\$
Gas/Electricity/Water:	\$
Telephone:	\$
Cable:	\$
Groceries:	\$
Daycare:	\$
Car Payment/Transportation Costs:	\$
Medical Expenses:	\$
Other Expenses:	\$
	\$
	\$
	\$
Total Expenses:	\$

Note to SIS briefly describing your situation:

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Please authorize page 4 and forward it to Dr. and or Social Worker for supporting documentation and information. Please include a few copies of any of your personal billing statements and or letters from creditors or social workers verifying your need for assistance. It may take up to 90 days for review and approval process. Please call SIS to verify receipt of application and for status information.

Physician Verification Form Please complete this form & return it to SIS Page 4

The individual listed below has requested assistance from SIS and has stated that s/he is unable to earn usual income due to breast cancer treatment.

I _____ Hereby Authorize _____
(Print your name) (Dr. /agency that you are requesting information)

to release information regarding my breast cancer diagnosis and treatment to SIS. This information is needed to determine my eligibility for assistance from SIS.

(Signature) (date) (Social Security #)

Patient name:	
Patient date of birth:	
Physician's name:	
Physician's address:	
Physician's phone:	
Date of onset:	
Diagnosis and staging	
Treatment plan/schedule include start date & projected end date	
Medications prescribed:	
Patient's prognosis:	
Specific physical limitations:	
Is patient's condition suitable for employment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, projected date _____
Comments:	

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Physician's signature _____ Date _____