



The Indiana Breast Cancer Awareness Trust (IBCAT) exists to increase awareness and improve access to breast cancer screening, diagnosis and support services throughout Indiana. Through license plate sales and donations we are able to provide financial assistance to individuals in active breast cancer treatment or who are living with breast cancer and may be struggling with financial hardships. Assistance will come in the form of egiftcard(s) and may be used for groceries and/or gasoline as selected below.

ELIGIBILITY

To qualify for assistance, applicants must be an Indiana resident currently undergoing active treatment for breast cancer such as radiation therapy, chemotherapy, within four week recovery period of mastectomy with or without breast reconstructive surgery, or in treatment for metastatic breast cancer. Household income must be 350% or below Federal Poverty Level (FPL). Visit www.fplcalculator.com to see if you qualify.

HOW TO APPLY

The patient should complete page one and sign the consent on page two. Page 2 **must** be completed, signed, and submitted by the patient’s oncologist or nurse navigator via one of the methods listed below.

MAIL: Indiana Breast Cancer Awareness Trust
 PO Box 8212
 Evansville, IN 47716

EMAIL: info@breastcancerplate.org

*Please allow 7-10 business days for processing.

APPLICANT INFORMATION

First Name: _____ M.I. _____ Last Name: _____

Address: _____

City, State, Zip: _____ County of Residence: _____

Phone: _____ Email (required): _____

Gender: Female Male | Age: _____ | Marital Status: Single Married Widowed

Race: African-American/Black White Asian Hispanic Other: _____

HOUSEHOLD SIZE: _____ **ANNUAL HOUSEHOLD INCOME:** _____

PREFERRED CARD(S) (not exceeding \$150):

Select One: Grocery \$150 Grocery \$75, Gas \$75 Gas \$150

Note: Card(s) will be issued electronically and sent to your email address from “Your Digital Rewards”.



PHYSICIAN VERIFICATION (This page **must** be completed by listed patient's oncologist or nurse navigator and submitted as directed on Page 1.)

Regarding the care and treatment of _____, I hereby verify that I am their physician and that under my supervision they are receiving treatment for breast cancer:

OFFICIAL DIAGNOSIS _____

Initial Diagnosis Date: _____ Recurrence Date: _____ Metastasis Date: _____

TREATMENT PLAN*

Start Date (mm/yy) End Date (mm/yy)

Mastectomy Date: _____ Chemotherapy _____

Lumpectomy Date: _____ Radiation _____

Other Date: _____

**Please note: Lumpectomy alone, 5-day targeted radiation, hormonal therapy or elective prophylactic mastectomy with or without breast reconstruction are not qualifying therapies.*

Please list current medications related to breast cancer treatment:

PHYSICIAN INFORMATION

Name: _____ Signature: _____

Healthcare Sys./Group: _____ Phone: _____

Address: _____ City/State/Zip: _____

Patient Navigator/Nurse First & Last Name: _____

Phone: _____ Email: _____

PATIENT INFORMATION

Patient First & Last Name: _____ Phone: _____

PATIENT CONSENT FOR IBCAT TO CONTACT MY SUPERVISING PHYSICIAN

I, the undersigned and above referenced and identified Applicant, hereby consent to the Indiana Breast Cancer Awareness Trust (IBCAT) contacting my supervising physician, identified above, to verify that I have breast cancer, my treatment and my restrictions relative to receiving services from IBCAT, I request that my physician complete this form, verify the information requested above, clarify if needed by IBCAT, and return this form to me or IBCAT. This consent expires thirty (30) days after the date below.

I also hereby verify that the above information is correct and attest that I will use the financial assistance cards as intended. I am responsible for safe keeping of the cards whether in my physical possession or received digitally. If I lose the cards, I understand that they will not be able to be replaced.

Applicant Signature: _____ **Date:** _____