



## Financial Request Form

The mission of Circle of Hope is to be a financial, informational, and emotional resource for individuals with breast cancer in Kenosha Wisconsin. Circle of Hope assists breast cancer patients regardless of age, gender, race, or religion. **To be eligible for financial assistance you must be a breast cancer patient currently receiving treatment.**  
**You must also be a Kenosha County resident and/or receive your treatment in Kenosha County**

Send your request form and receipts to: Circle of Hope, 8208 43<sup>rd</sup> Ave, Kenosha, WI 53142

Applicant's Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ WorkPhone: \_\_\_\_\_

Person completing the form: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_

I authorize a representative from Circle of Hope to verify with my physician that I am in treatment for breast cancer.

Applicant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### **This Section to be Completed by Oncologist/Surgeon**

(Name) \_\_\_\_\_ is my patient and is currently receiving treatment for breast cancer.

Doctor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's name (print): \_\_\_\_\_

Doctor's phone number: \_\_\_\_\_

Location of Treatment (Clinic & City)  
\_\_\_\_\_

Treatment Type:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Oncologist/Surgeon Continued

Other Information  
(Optional): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This Section to be Completed by Breast Cancer Patient**

<b>Request</b>	<b>Amount Requested</b>	<b>Check Payable to</b>
Physician fees _____		
Diagnostic tests _____		
Hospital expenses _____		
Bras _____		
Prosthesis _____		
Lymph edema Sleeves/Supplies _____		
Wigs _____		
Other: _____		

**Please check here if you have received a grant from COH in the past \_\_\_\_\_. Proof of residency required. Copies of the bills/statements must be attached to the application to receive payment. Please send copies only and retain the original bills/statements for your file. If your request is approved, Circle of Hope will make the check payable to the clinic, hospital, etc. The checks will be mailed to you, and it is your responsibility to distribute the checks to the appropriate places.**

Briefly add any other information that you think would be helpful for the committee:

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I certify that the above information is true and complete to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If you have questions, please call Circle of Hope (262) 697-0655.

The Circle of Hope Foundation will assist individuals who are diagnosed with breast cancer. The decision on the course of treatment is the sole responsibility of the individual with breast cancer. Circle of Hope bears no responsibility to seek or not to seek any treatment options.  
Updated 10/20/10