GRANT APPLICATION INSTRUCTIONS

The Karen P. Nakon Breast Cancer Foundation is a non-profit 501c3 tax-exempt organization committed to providing financial assistance to individuals impacted by the financial burden of a breast cancer diagnosis.


- Applicants are only eligible for assistance once in a calendar year (12 months).

- This application must be complete. Answer each question or indicate with a N/A if an item does not apply to your situation. Incomplete applications will not be accepted or reviewed and will be returned.

- A current pathology report and/or treatment plan reflecting the most current diagnosis information must be included with the application or the application will be considered incomplete.

- All parties must sign and date the application in all required places or the application will not be processed.

- Please do not staple the application components and do not use the backs of any pages.

- Type and amount of assistance will be determined on a case-by-case basis by the Nakon Foundation Board of Directors. Application submission does not assure assistance will be granted.

- The Nakon Foundation may only provide financial assistance to qualified individuals based upon a demonstration of need. The information you provide in this application will be used exclusively by the Foundation to determine your eligibility for financial assistance. The Nakon Foundation will not disclose or release the provided information to third parties without first obtaining your prior written consent.

- Approved applicant will be notified by mail and after proper billing paperwork is received, a one-time aid disbursement will be mailed directly to the third party billing entity.

<table>
<thead>
<tr>
<th>Applications Postmarked by</th>
<th>Grants Awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 20</td>
<td>March Board Meeting</td>
</tr>
<tr>
<td>May 20</td>
<td>June Board Meeting</td>
</tr>
<tr>
<td>August 20</td>
<td>September Board Meeting</td>
</tr>
<tr>
<td>November 20</td>
<td>December Board Meeting</td>
</tr>
</tbody>
</table>

Return Application and REQUIRED Pathology Report to:

The Karen P. Nakon Breast Cancer Foundation
35765 Chester Road
Avon, OH 44011
info@nakonfoundation.org
440-933-7621
CONFIDENTIAL APPLICATION FOR ASSISTANCE

Return Application and REQUIRED Pathology Report to:
The Karen P. Nakon Breast Cancer Foundation
35765 Chester Road
Avon, OH 44011
info@nakonfoundation.org

Emergency applications for review outside of the Nakon Foundation quarterly meetings must demonstrate an immediate need for the emergency by including copies of any bills, legal notices, estimates, etc.

Please indicate the type of emergency and paperwork included with the application:

☐ Eviction / Foreclosure - Paperwork included: ________________________________

☐ Utility shut off or disconnect—Paperwork included: __________________________

☐ Other (please explain) - __________________________________________________

Applicant’s Full Name: ______________________________________________________

Permanent Address: _________________________________________________________

City: __________________________ County: __________________________ State: ____ Zip: ____________

Current Address if different than above: _________________________________________

City: __________________________ County: __________________________ State: ____ Zip: ____________

Applicant Phone - Home: ___________ Cell: _____________ Work: _______________

Email address: ________________________________________________________________

DOB: ___________________ Age: __________ Race (optional): ___________________

Marital Status: ☐ Single ☐ Married ☐ Widowed

☐ Separated ☐ Divorced ☐ Living with partner

Spouse/Partner’s Full Name: __________________________________________________

Children and/or dependents and their relationship to you: Resides with you?

Name: _____________________ Age: ______ Relationship: ____________________________ ☐ Yes ☐ No ☐ PT

Name: _____________________ Age: ______ Relationship: ____________________________ ☐ Yes ☐ No ☐ PT

Name: _____________________ Age: ______ Relationship: ____________________________ ☐ Yes ☐ No ☐ PT

Name: _____________________ Age: ______ Relationship: ____________________________ ☐ Yes ☐ No ☐ PT
Medical Information

Please attach a copy of your complete pathology report and treatment summary for verification purposes. Application cannot be reviewed without this information.

Pathology Report Enclosed: ☐ Yes ☐ No Treatment Summary Enclosed ☐ Yes ☐ No

Physician’s Name: _______________________ Facility:_________________________ Phone:___________________

Social Worker’s Name:___________________ Facility:_________________________ Phone:___________________

Social Worker’s Email:___________________________________________________

Social Worker Notes (if applicable):____________________________________________________________________

_________________________________________________________________________________________________

Referred by:___________________________________________________________

Insurance and Prescription Information:

Type of Health Insurance (Please check all that apply):

☐ Private health insurance provider (Medical Mutual, Kaiser, etc.)
☐ Medicare plus Medicaid ☐ Medicaid ☐ Medicaid Pending
☐ Medicare plus other supplemental coverage ☐ Cobra
☐ Public Health Insurance ☐ Charity Care
☐ Disability ☐ VA Program ☐ None
☐ Other:______________________________________________________________

Are your prescription drugs covered? ☐ Yes ☐ No

Additional Aid and Assistance:

Have you received assistance from the Nakon Foundation in the past? ☐ Yes ☐ No

If Yes, Date: ___________ Amount: ___________ Purpose: ________________________________

Have you received assistance from any other cancer foundation? ☐ Yes ☐ No

If Yes, what is the name of the Foundation?____________________________________________

Date: ___________ Amount: ___________ Purpose: ________________________________

Do you currently have an application for assistance pending with another foundation? ☐ Yes ☐ No

If Yes, what is the name of the Foundation?____________________________________________
Income and Employment Status

Applicant’s current employer: __________________________________________________________

Occupation: ________________________________________________________________________

Status:  ☐ Full-time   ☐ Part-time   ☐ FMLA   ☐ Unemployed
        ☐ Retired   ☐ Disability   ☐ Other (please explain): ____________________________

Current monthly gross income:  $____________

From (please check all that apply):  ☐ Paycheck   ☐ Pension   ☐ Social Security   ☐ Disability
        ☐ Unemployment   ☐ Alimony   ☐ Food Stamps   ☐ Other (please explain): ____________________________

If currently unemployed, please identify previous employer and term of employment and/or explain employment history
(ex: stay-at-home mom, laid off in 2010, unable to work because): ____________________________

Spouse/Partner’s current employer: _____________________________________________________

Occupation: ________________________________________________________________________

Status:  ☐ Full-time   ☐ Part-time   ☐ FMLA   ☐ Unemployed
        ☐ Retired   ☐ Disability   ☐ Other (please explain): ____________________________

Current monthly gross income:  $____________

From (please check all that apply):  ☐ Paycheck   ☐ Pension   ☐ Social Security   ☐ Disability
        ☐ Alimony   ☐ Food Stamps   ☐ Other (please explain): ____________________________

Additional Person’s Employed in the Household’s current employer: __________________________

Occupation: ________________________________________________________________________

Status:  ☐ Full-time   ☐ Part-time   ☐ FMLA   ☐ Unemployed
        ☐ Retired   ☐ Disability   ☐ Other (please explain): ____________________________

Current monthly gross income:  $____________

From (please check all that apply):  ☐ Paycheck   ☐ Pension   ☐ Social Security   ☐ Disability
        ☐ Alimony   ☐ Food Stamps   ☐ Other (please explain): ____________________________

Total Gross Monthly Income (from above):  $____________

Public or Private Financial Assistance you are receiving:  $____________

TOTAL HOUSEHOLD INCOME:  $____________
Biography/Needs Assessment

This section provides an opportunity to share your story, specifically how cancer has impacted you financially. Please use the space below to indicate your specific circumstances (duration of your cancer, immediate needs you have, special work/income limitations, etc.). If financial information indicated that your current income exceeds your expenses, please explain circumstances.

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Financial Statement and Needs Assessment

Assets:

Total Cash and Non-Retirement Bank Accounts (checking, savings, cds, etc): $____________
Retirement Accounts (include IRA, 401(k), 403(b), pensions and profit sharing) $____________
Investments (stocks, bonds, mutual funds, brokerage accounts, etc.) $____________
Real Estate: Value of Residence $____________

Value of Rental Property/Vacation Property $____________
Automobiles: $____________

Total Assets: $____________

Debts:

<table>
<thead>
<tr>
<th>Monthly Payment</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage (for your home, excluding taxes and insurance)</td>
<td>$________</td>
</tr>
<tr>
<td>Real Estate Taxes</td>
<td>$________</td>
</tr>
<tr>
<td>Rent</td>
<td>$________</td>
</tr>
<tr>
<td>Other loans (personal, home equity, lines of credit)</td>
<td>$________</td>
</tr>
<tr>
<td>Student Loans</td>
<td>$________</td>
</tr>
<tr>
<td>Auto Loans</td>
<td>$________</td>
</tr>
<tr>
<td>Credit Card Debt</td>
<td>$________</td>
</tr>
<tr>
<td>Monthly Utilities (gas, electric, phone, water, sewer, etc.)</td>
<td>$________</td>
</tr>
<tr>
<td>Food</td>
<td>$________</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>$________</td>
</tr>
<tr>
<td>Other Debts and Monthly Expenses</td>
<td>$________</td>
</tr>
<tr>
<td>Total Debt:</td>
<td>$________</td>
</tr>
</tbody>
</table>

Amount that you are requesting $____________

Purpose:__________________________________________________________________________________________

I understand that the Nakon Foundation will rely upon the truth and accuracy of the above.
If this application is not completely filled out or does not include a pathology report with course of treatment,
the application will not be accepted nor considered for assistance.

Applicant Signature:_____________________________________________________  Date:______________________
Publicity Release

The Karen P. Nakon Breast Cancer Foundation holds events and fundraisers throughout the year to raise money to fund the grants to help families endure the staggering costs of breast cancer treatments. We could use your help to put a face and a name to this cause.

To this end we ask for your permission to use your photo, your story, and a brief description of how the money that you received from The Foundation has helped you. This will assist us in communicating to our donors and reporting to the community on the work that is being done and in turn assist in our fund raising efforts. Please indicate your permission and/or interests by checking the appropriate areas:

☐ Use of photo
☐ Use of your background information
☐ Use of your First Name
☐ Use of your First AND Last Name
☐ Willing to be contacted to speak at fundraising events on behalf of the Foundation
☐ NO, I prefer to remain anonymous.

I understand this will not in any way exclude me from receiving assistance.

Permission to use the checked information above is given to The Karen P. Nakon Breast Cancer Foundation for use in PR and Marketing materials which will include, but not be limited to, annual reports, newsletters, website and brochures.

_____________________________________________________________________________________________________

Signature of Applicant Date
Medial Record Release and Authorization

Ohio and Federal law protect the privacy and confidentiality of an individual patient’s medical records. In order for The Karen P. Nakon Breast Cancer Foundation to access your medical records (as part of its financial assistance process), a Release and Authorization Form must be executed and submitted to your health care provider(s). Please note that you are afforded the following rights with respect to the Release and Authorization:

• You may refuse to sign the Release and Authorizing Form, although you will then be ineligible to receive financial assistance from The Foundation.

• You may revoke the Release and Authorization by submitting a written revocation to the health care provider.

• The revocation will be effective upon receipt by the healthcare provider.

• You have the right to receive a copy of this Release and Authorization upon written request.

• You may inspect or obtain copies of all information which the Foundation receives pursuant to this Release and Authorization.

Name: ___________________________________________ DOB: ______________________

Street Address: ________________________________________________________________

City, State, Zip: ________________________________________________________________

Phone Number: ___________________________ Last 4 digits of SSN: _________________

I hereby authorize ____________________________________________________________

(Health Care Provider)

to release all pathology reports, copies of charts and medical information regarding my treatment plan to The Karen P. Nakon Breast Cancer Foundation at 35765 Chester Road, Avon, OH 44011.

The purpose of this request is to assist The Karen P. Nakon Breast Cancer Foundation in determining my eligibility for financial assistance.

This Release and Authorization shall expire twelve (12) months form its execution if not revoked prior thereto.

The Foundation will not disseminate or release your medical records to any outside source without first obtaining your prior express consent.

__________________________________________________________  __________________________
Signature of Applicant                                      Date