INDIANA WOMEN IN NEED FOUNDATION, INC.

Dear Applicant:

The Indiana Women In Need Foundation (I.W.I.N.) was created to assist women and their families undergoing breast cancer treatment, by providing individualized services. Awards are offered in an amount not to exceed **$500***. These funds are used to pay for personal services, selected by each recipient. I.W.I.N. services are listed below. To qualify for assistance, applicants must be undergoing treatment for breast cancer by currently receiving one or more of the following treatments: chemotherapy, radiation, or surgery. **These are one time awards.**

To apply, please complete and sign the following pages. Page two must be completed by your treatment physician (surgeon or oncologist). Submit the application as soon as possible; patient must be in active treatment to qualify.

Mail your application to: I.W.I.N. Foundation
P.O. Box 30648
Indianapolis, IN 46220
(317) 475-0342 FAX

We look forward to serving you. Feel free to call with any questions at (317) 475-0565 or toll free 866-900-4946.

Applicant's Full Name: First: ____________________________M.I.______________________

Last: ____

Address: ____

City, State, Zip:____

Phone:(____)____________________ E-mail Address: ________________________________

County of Residence: ___________________ Date of Birth: ________________ Age ______

Alternative Contact (Optional): Name: _____________________ Phone Number: ___________

Please select the service(s) that would be most beneficial to you:

______ Housekeeping ______Yard Maintenance ______ Massage Therapy
______ Childcare ______ Photography ______ Yoga Classes
______ Meals (grocery gift cards) ______ Exercise Class
______ Transportation Support (gasoline gift cards or bus pass)

*Subject to change based on economic conditions and individual circumstances.

Physician's Verification of Patient/Applicant's Treatment

Regarding the care and treatment of ______________________________________, I, hereby verify that I am her physician and that under my supervision she is receiving treatment for breast cancer in the form of:

Treatment
Mastectomy Date: ____________
Lumpectomy Date: ____________

**Please note that a lumpectomy alone, mammosite radiation, hormonal therapy, or reconstruction are not qualifying therapies.*

	Start Date (mm/yy)	End Date (mm/yy)
Chemotherapy	____________	____________
Radiation	____________	____________

Please list current medications related to breast cancer treatment: _________________________
____

Diagnosis Status:
Initial diagnosis - Date: ________ Recurrence - Date: ________ Metastasis - Date: ________

Patient Name: ________________________

Patient Address:__________________

City: ________________________________

State/Zip: ____________________________

Phone Number: (______)_________________

Physician's Signature: ________________________

Printed Name:______________________________

Printed Address: __________________________

City, State, Zip: ____________________________

Specialty: _________________________________

Social Worker/Navigator/RN:_________________

Phone Number: (_____) _____________________

Health Care System or Group: ________________

Consent for I.W.I.N. to Contact my Supervising Physician

I, the undersigned and above referenced and identified Applicant, hereby consent to the Indiana Women In Need Foundation Inc. ("I.W.I.N.") contacting my supervising physician, identified above, to verify that I have breast cancer, my treatment and my restrictions relative to receiving services from I.W.I.N.. **I request that my physician complete this form, verify the information requested above, clarify if needed by I.W.I.N., and return this form to me or I.W.I.N.**. This consent expires thirty (30) days after the date below.

_________________________ ____
Date Applicant's Signature

Demographic Profile

Please complete this page in it's entirety. The information you provide will not affect your award but it is necessary for future I.W.I.N. funding and grant recording.

Name: ____

Race: (please check)
___ African-American
___ American Indian
___ Asian
___ Caucasian
___ Hispanic
___ Other/Explain ____________

Date of Birth: ___________________

Age: _________

Marital Status:
Single: ______
Married: ______
Widowed: ______

Do you have others living with you? Yes _____ No ____ If yes, how many? ______
What is their relationship to you and age?
____

Do you have health insurance? Yes _____ No ____
Are you employed? Yes _____ No ____

Annual Household Income:

___ 0-10,000
___ 10,001-20,000
___ 20,001-30,000
___ 30,001-40,000
___ 40,001-50,000
___ 50,000-60,000
___ 60,000-70,000
___ 70,000-80,000
___ 80,000-90,000
___ 90,000-100,000
___ 100,000 and over

How did you find out about us?
____
____

Is there anything else we should know about your situation? (optional):

____

____

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APPLICANT AGREEMENT

I, the undersigned and above-identified Applicant, have read, acknowledge, understand and agree to the following terms in order to receive benefits and services from I.W.I.N.:

1. I consent to I.W.I.N. contacting my supervising physician to verify that I have breast cancer and to verify my treatment. I will obtain my physician's signature on the enclosed verification form, or make arrangements to obtain such verification.

2. I understand that I.W.I.N. only provides assistance to help me be able to do household and family activities and/or to obtain goods and services. I am solely responsible for selecting and supervising desired services. I agree that I will not hold I.W.I.N. liable and hereby release I.W.I.N. and its agents, officers, directors & staff from any damages or claims that are a result of the services for which I receive benefits or reimbursement in connection with this Agreement.

3. I.W.I.N. provides monetary assistance only for the services and/or goods that I receive. I.W.I.N. will pay a cumulative dollar total no greater than the amount specified in the Acceptance as reimbursement for services provided to me by my third party providers. If I so direct, I.W.I.N. may send payment directly to a third party provider for my benefit upon notice and receipt of services. I am responsible for arranging for payment.

4. I personally, not I.W.I.N., will hire, employ, and request services from all third party providers. I will not seek reimbursement for services that are illegal, are unethical, are not actually received, or will be paid/reimbursed by another party. I understand and will not seek reimbursement for services provided to me by family members. Any potential third party providers identified or named by I.W.I.N. or one of its agents do not constitute recommendations or any guarantee of quality service, but are merely identification of third parties that claim to provide such services. I.W.I.N. is not responsible and I will hold I.W.I.N. harmless and not liable for any damages, claims action or inaction (negligent, intentional, reckless or otherwise) of third party provider(s) or related to any provided services or goods, when reimbursed by I.W.I.N. I further agree to indemnify I.W.I.N. for all damages, claims or actions related to said services, goods or this Agreement.

5. Unless sooner terminated in writing by either party, this agreement shall remain in effect until the ending date stated in the Acceptance or my total benefit limit has been reached. Under no circumstances will I.W.I.N. be expected to pay, reimburse or incur expenses in excess of the total dollar value indicated on the Acceptance in regard to this Applicant, and Applicant shall refund or reimburse any amounts in excess of such value paid or incurred.

6. The parties shall use reasonable efforts (including mediation) to resolve any differences arising between them as a result of this agreement prior to exercising their respective rights at law or equity in the Superior/Circuit Courts of Marion County, Indiana. Applicant shall provide prompt notice to I.W.I.N. regarding any litigation or proceeding related to this Agreement or covered services.

7. I acknowledge that I have read and understand this agreement and shall be bound by its terms. If I.W.I.N. provides assistance to Applicant, this is the entire agreement between the parties and supersedes all prior proposals and understandings between the parties. This agreement may not be modified or amended except by a written document signed by the party against whom enforcement is sought.

____ ____

Date	Applicant's Signature