INDIANA WOMEN IN NEED FOUNDATION, INC.

Dear Applicant:

The Indiana Women In Need Foundation (IWIN) 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 **$400***. These funds are used to pay for personal services, selected by each recipient. IWIN 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: IWIN Foundation
P.O. Box 30648
Indianapolis, IN 46220
(317) 475-0342 FAX
debbiel@iwinfoundation.org

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	_____ Eldercare	_____ Yoga Classes
_____ Meals (grocery gift cards)		_____ Exercise Class
_____ Transportation Support (gasoline gift cards or bus pass)		_____Medication Assistance

*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, 5 day targeted 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: _____ Physician's Signature: _____

Patient Address:_____ Printed Name:_____

City: _____ Printed Address: _____

State/Zip: _____ City, State, Zip: _____

Phone Number: (_____)_____ Specialty: _____

Social Worker/Navigator/RN:_____

Phone Number: (_____) _____

Health Care System or Group: _____

Consent for IWIN to Contact my Supervising Physician

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

_____ _____

Date Applicant's Signature

Demographic Profile

Please complete this page in its entirety. The information you provide will not affect your award but it is necessary for future IWIN 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):

_____

_____

_____

_____

_____

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 IWIN:

1. I consent to IWIN 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 IWIN 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 IWIN liable and hereby release IWIN 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. IWIN provides monetary assistance only for the services and/or goods that I receive. IWIN 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, IWIN 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 IWIN, 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 IWIN 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. IWIN is not responsible and I will hold IWIN 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 IWIN I further agree to indemnify IWIN 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 IWIN 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 IWIN 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 IWIN 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