Caring In Our Lifetime
The Local Fight Against Breast Cancer
In Horry & Georgetown Counties of South Carolina
P.O. Box 1193 • Myrtle Beach, SC 29578 • 843.497-3609

PRE-REGISTRATION QUESTIONNAIRE - STEP 1

1. ARE YOU A US CITIZEN? YES or NO
2. ARE YOU A FULL TIME RESIDENT OF HORRY OR GEORGETOWN COUNTY? YES or NO

   IF YES, PLEASE STATE THE COUNTY _____.
3. HAVE YOU BEEN DIAGNOSED WITH BREAST CANCER? YES or NO

   IF YES, WHEN_____

   NAME OF PHYSICIAN WHO DIAGNOSED YOU_____

   ADDRESS OF PHYSICIAN_____

   TELEPHONE # OF PHYSICIAN=S OFFICE_____ and

   FAX # OF PHYSICIAN=S OFFICE_____
4. ARE YOU A SINGLE INCOME HOUSEHOLD MAKING LESS THAN $45,000? YES or NO
   OR ARE YOU A MULTIPLE INCOME HOUSEHOLD FILING JOINTLY WITH AN INCOME OF LESS THAN $75,000? YES or NO
5. DO YOU HAVE MEDICAL/HEALTH INSURANCE? YES or NO or N/A

   IF YES, WITH WHOM?_____
6. ARE YOU IN CURRENT NEED OF TREATMENT? YES or NO
7. ARE YOU CURRENTLY RECEIVING TREATMENT? YES or NO

   TREATING PHYSICIAN=S NAME ADDRESS AND TELEPHONE NUMBER_____
   _____
8. WHO REFERRED YOU TO >CARING IN OUR LIFETIME=?_____
9. PLEASE LIST ALL OF YOUR LIQUID ASSETS IF MORE THAN $50,000.

   _____

   _____

_____

_____

IF YOU HAVE ANSWERED YES TO # 1, 2, 3, 4, 6 AND 7, PLEASE MAIL THIS COMPLETED FORM WITH THE LAST 2 YEARS OF YOUR COMPLETE FEDERAL TAX RETURNS (SCHEDULES A & B) TO:

CARING IN OUR LIFETIME
PO BOX 1193
MYRTLE BEACH, SC 29578

Detailed Description of Situation: Please fill in below (or attach a separate sheet of paper) that describes your breast cancer diagnosis. Please include a medical report signed by your physician.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Physician Verification: If a physician signed this or an attachment, please print that physician=s name and contact information.

Name:_____ Phone:_____
Address:_____ Fax:_____
_____ E-mail:_____
City, State, ZIP:_____

_____

Date:_____ Signature:_____

_____Amount of Caring In Our Lifetime Discretionary Funds Involved if any)

We, the undersigned, have reviewed this grant request and hereby give our approval or disapproval:

Signature: Date: ___/___/___ Approved _____ Disapproved _____

_____

Signature: Date: ___/___/___ Approved _____ Disapproved _____

_____

Signature: Date: ___/___/___ Approved _____ Disapproved _____

_____

Approval of funding does not create a contract or right to assistance. Caring In Our Lifetime retains the right to approve, disapprove, accept, withdraw approval or reject any requests at its sole discretion.

Pre-approval recipient application
breast cancer patient
to cover expenses directly related to
medical treatment for breast cancer.
Please Print

Name:_____

Address:_____

_____

Date of Birth:_____

Phone Number:_____

Alternative Phone Number:_____

Employer:_____

Work Phone #:_____

This pre-approval recipient application is not a contract. Caring In Our Lifetime reserves the right to accept or reject all applications or requests or withdraw approval at its sole discretion.

APPROVED FUNDS CANNOT BE USED FOR TREATMENT GIVEN PRIOR OR AFTER THE CURRENT DIAGNOSIS OF BREAST CANCER.

RELEASE OF MEDICAL INFORMATION TO CARING IN OUR LIFETIME

FACILITY/PHYSICIAN:_____

ADDRESS:_____

_____

_____

TO: CARING IN OUR LIFETIME, RECIPIENT DIRECTOR
P.O. BOX 1193
MYRTLE BEACH, SC 2958

CARING IN OUR LIFETIME HAS ACCEPTED YOUR PATIENT INTO ITS PROGRAM WHICH MAY ALLOW THE PATIENT TO RECEIVE ASSISTANCE IN THE PAYMENT OF THEIR BREAST CANCER RELATED MEDICAL BILLS. WE WOULD LIKE TO CONTACT YOU TO DISCUSS PAYMENT OF THEIR OUTSTANDING DEBT.

RECIPIENT=S NAME:_____

DATE OF BIRTH:_____

INFORMATION REQUESTED:

_____ ENTIRE ITEMIZED BILL

_____ OTHER_____

_____

_____ _____
Caring In Our Lifetime Representative Requesting Medical Information Date

_____
Recipient Signature

THIS RELEASE DOES NOT OBLIGATE CARING IN OUR LIFETIME TO MAKE ANY PAYMENT TO THE PATIENT OR MEDICAL PROVIDER. CARING IN OUR LIFETIME RETAINS THE RIGHT TO ACCEPT OR REJECT ANY REQUEST OR WITHDRAW ANY APPROVAL AT ITS SOLE DISCRETION.