

AVAILABLE – January 20, 2025 to February 17, 2025



HOUSTON-AREA SURVIVORS BREAST CANCER ASSISTANCE PROGRAM (BCAP) APPLICATION

BCAP is supported by The University of Texas MD Anderson Cancer Center.

Email to: bcap@sistersnetworkinc.org



**ARE YOU A BREAST CANCER SURVIVOR IN ACTIVE TREATMENT AND LIVE IN GREATER HOUSTON AREA?
WE HAVE FINANCIAL ASSISTANCE TO SUPPORT YOU.**

BCAP HISTORY & IMPACT

Sisters Network® Inc. Karen E. Jackson Breast Cancer Assistance Program is one of leading breast cancer survivor financial assistance and early detection mammogram programs in the United States. Founded in 2006, the BCAP has provided over 1.6 million dollars in financial assistance and free 3D mammogram screenings.

To be considered for Financial Assistance, please provide the following:

1. Completed BCAP Application
2. Required Email Address: Must be provided to receive progress updates
3. ***EMAIL ONLY ONE:** Utility bill (Gas, Electric or Water), Lease Agreement or Mortgage Statement (must be scanned and show mailing address)
4. Signed Terms and Conditions
5. Provide proof of current type of eligible treatments or treatment plan (IV or Port Chemotherapy, Radiation)

Note: BCAP program may close early due to funding being depleted or extended if additional funds additional funds are received.

PICK ONE ITEM—ASSISTANCE WILL BE AWARDED UP TO \$250

ASSISTANCE CATEGORIES: Utility Bill (Gas, Water or Electric) Rent Mortgage
 \$150 Grocery gift card for HEB or Walmart (*Select One*)

How did you hear about the Breast Cancer Assistance Program (BCAP)?

- | | |
|---|---|
| <input type="checkbox"/> Sisters Network website | <input type="checkbox"/> Breast Cancer Survivor |
| <input type="checkbox"/> Email | <input type="checkbox"/> Cancer Organization <i>please list</i> _____ |
| <input type="checkbox"/> Facebook/Instagram/X(formerly Twitter) | <input type="checkbox"/> Other _____ |

How have you been impacted? Lost job

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Lost health insurance | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Had a treatment plan change | |

ALL INFORMATION MUST BE COMPLETED.

SUBMIT TO bcap@sistersnetworkinc.org

- Application **must** be **SCANNED (no photographs accepted) NO EXCEPTIONS.**
- Only **complete applications** will be processed. ***Incomplete applications will not be reviewed and/or processed***
- Please allow 30 days for review and processing.
- If approved, payments are made directly to the Third-Party Provider.
- Submission of this application does not imply or guarantee approval of financial assistance.

Visit sistersnetworkinc.org/programs to download the application.

Email completed application to BCAP@sistersnetworkinc.org.

(NO MAILED APPLICATIONS ARE ACCEPTED)

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PERSONAL INFORMATION

Today's Date: _____

First and Last Name: _____

Age: 20-30 31-40 41-50 51-60 61-70 71+

Cell Phone: _____ Email: _____

Current address: _____

City: _____ State: _____ Zip Code: _____

RACE/ETHNICITY INFORMATION: *(Check one)*

- | | |
|--|--|
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Hispanic or Latino | <input type="checkbox"/> American Indian or Alaska Native |
| <input type="checkbox"/> White | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander |

You must be currently **IN ACTIVE TREATMENT** and provide proof of receiving one of the following:

- Radiation IV/Port Chemotherapy

ASSISTANCE REQUESTED *(please select one)*

Please check which category of assistance: Utilities Rent Mortgage \$150 Grocery gift card for
 HEB or Walmart (*Select One*)
(mailed to survivor)

FINANCIAL STATUS

Are you currently employed? Yes No Do you have insurance? Yes No

If Yes, please name occupation: _____

If No, state reason _____

Annual Household Income under \$25K \$25K-\$49,999 \$50K-\$69K \$70K+

Head of Household Yes No

Number in Household: _____

List Sources of Income:

- Employment Child Support Public Assistance Family/friends provide support
 Social Security (Retirement) Pension Disability Unemployment

EDUCATION LEVEL

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Some School GED High School Graduate Some College College Graduate Post-Graduate

BREAST CANCER STATUS

Year diagnosed: _____

Have you had multiple diagnoses? Yes No If yes, how many? _____

Type of Breast Cancer: DCIS TNBC IDC HR+ HR- Inflammatory Other

Current Stage of Breast Cancer: Stage 0 Stage 1 Stage 2 Stage 3 Stage 4

TREATMENT *(please fill out completely)*

Currently in treatment? Yes No IV Chemotherapy Radiation Therapy
(If no, you are not eligible.)

Treatment dates: _____ *(Attach letter from physician for verification.)*

Start: _____ Approximate End: _____

Treatment/Medication: _____

PHYSICIAN CONTACT

Physician Name: _____

Organization/Hospital: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Email: _____

TERMS AND CONDITIONS

- **ALLOCATION OF FUNDS:** Sisters Network® Inc. (SNI) Board of Directors allocates certain monies and other resources to the Breast Cancer Assistance Program (BCAP) through the annual budget. The number and size granted by the Breast Cancer Program is dependent upon the allocation of Sisters Network resources to the Breast Cancer Assistance Program within Sisters Network annual budget. Sisters Network Board of Directors has exclusive determination as to those monies and resources.
- **SELECTION PROCESS:** The BCAP application, including the selection of the successful applicant is reviewed by the National Office. Sisters Network National Office reserves the right to decline a request, and/or partially grant a request based upon the allocation of funds to the program. REVIEWING OF THIS APPLICATION DOES NOT CONSTITUTE ANY PROMISE OR ASSURANCE BY SISTERS NETWORK (OR ANY OF ITS REPRESENTATIVES) TO AN APPLICANT REGARDING THE GRANTING OF THEIR FUNDING REQUEST.
- **GRANTS OF RIGHTS, RESTRICTIONS ON USE:** The information provided by applicant herein will only

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be utilized for Sisters Network® Inc. consideration of your BCAP Application and our mailing list/marketing. Your information will not be shared with anyone unaffiliated with Sisters Network. Should your request be granted, Sisters Network will not communicate with any third parties relating to your request without your prior consent. Sisters Network reserves the right to utilize your Breast Cancer Assistance Program experience to share with potential sponsors as well as the general public in order to promote the Breast Cancer Assistance Program to other women cancer survivors that could potentially participate in this program. Sisters Network reserves the right to terminate the Breast Cancer Assistance Program at any time due to budget restraints or mitigating circumstances.

- **TIME FRAME OF PROCESS:** The complete review/approval process takes approximately 30 business days from the date that Sisters Network® Inc. received the entire BCAP application package.

I affirm that I have read all of the above important information, and attest that the information provided by me in this application is true and correct to the best of my knowledge.

Applicant Signature: _____

Printed Name: _____

Date Signed: _____

Email application and supporting PDF/JPG materials to: BCAP@sistersnetworkinc.org.

BREAST CANCER ASSISTANCE PROGRAM (BCAP)

- This program assists breast cancer survivors currently in active treatment and facing financial challenges.
- Financial Assistance is paid directly to third-party providers for utilities (gas-water-electric), mortgage or apartment rental.
- Please allow 30 for review and processing.
- Grocery gift card will be mailed directly to survivor

