joy of dawn
Compassionate. Empowering. Supportive.

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for your interest in Joy of Dawn assistance for fighters!

We provide financial assistance to those who miss work during breast cancer treatments and have trouble paying household bills. The last thing a cancer patient needs is the added stress that comes with the financial burdens related to cancer care. We provide short-term financial assistance for routine monthly bills.

You must meet these qualifications to be considered for assistance.

1. **You are currently fighting breast cancer.**
2. **You or our partner/spouse are missing income due to the breast cancer treatment.**
3. **You do not qualify for Social Security Income or Social Security Disability.**

Please fill out the attached application then mail to:

Joy of Dawn

226 Keller Ln. #7156

Maryville, TN 37801

Once Joy of Dawn receives the application, it may take up to 14 days for review by the Joy of Dawn financial assistance committee.

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APPLICATION FOR FINANCIAL ASSISTANCE

Name: _____Date of Birth: _____/_____/_____

Street Address: _____ Phone#: _____

City: _____State: _____ Zip: _____County: _____

Email Address: _____

Please list all members of the household:

Name	Relationship	Age	Annual Income

Have you applied for Social Security Disability? Yes/No
Are you receiving Social Security Disability? No___ Yes ___ Date approved_____

Health Insurance: ☐ None ☐ SSI ☐ Employer/Spouse Employer ☐ Private ☐ COBRA

Patient Employment Status Before Breast Cancer:
☐ Full-time ☐ Part-time ☐ Unemployed Last work date: _____

Employer: _____ Monthly Income: _____

Patient Current Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed ☐ FMLA ☐ Disability/Sick Leave

Currently Receiving Compensation Y/N Monthly Income:_____

Spouse/Partner Employment Status Before Breast Cancer:
☐ Full-time ☐ Part-time ☐ Unemployed Last work date: _____

Employer: _____ Monthly Income: _____

Spouse/Partner Current Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed ☐ FMLA ☐ Disability/Sick Leave

Currently Receiving Compensation Y/N Monthly Income: _____

Expense	Monthly Amount	Expense	Monthly Amount
Mortgage/Rent		Phone	
Auto Loan 1		Internet	
Auto Loan 2		TV	
Auto Insurance		Other	
Utilities		Other	

Please include a complete copy of the bills you would like Joy of Dawn to consider for payment. When added together the bills must not exceed $1,000. Do not include bills for health insurance or medical bills as they do not qualify for our assistance.

Applicants who rent or lease must submit a copy of rental/lease agreement. Agreement must include payment information.

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Physician's Statement

Must be completed and signed by Physician or Nurse Navigator

Patient Name: _____ Date: _____

Date of Breast Cancer Diagnosis: _____ Stage: _____

Breast Cancer Diagnosis:

_____

_____

_____

Breast Cancer Treatment:

Surgery Date: _____ Lumpectomy Y/N _____ Mastectomy Y/N _____

Chemotherapy Y/N _____ Start Date: _____ Projected End Date_____

Radiation Y/N _____ Start Date: _____ Projected End Date_____

Additional treatments not listed above:

_____

_____

_____

Signature: _____ Date: _____

Printed Name _____ Title: _____

Email: _____ Phone: _____

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the use or disclosure of protected health information concerning my breast cancer diagnosis and treatment to Joy of Dawn, Inc.

This authorization shall expire in 6 months.

Signature: _____ Date: _____

Printed Name: _____