ASSISTANCE PROGRAM APPLICATION

The Bettie Lott and Vera Times Foundation's purpose is to provide comprehensive support to individuals affected by hardship, illness, or crisis. The foundation also supports public health research and educational programs within the U.S. and around the world. Our current program is to provide financial support to individuals currently in cancer treatment.

Program Overview

- Funds may be used for daily living cost such as rent, utilities, food, transportation, childcare, etc.
- Payment is based on available funding.

Eligibility Criteria

- Must be in active treatment for cancer.

INSTRUCTIONS OF APPLICATION

1. Complete the Application.
2. Submit completed application to admin@bettieandvera.org

*****Incomplete or unsigned applications will not be considered for funding*****

TERMS & CONDITIONS

The data you provide herein will be used as set forth in BVLT Privacy Policy. BVLT, its employees and agents are hereby authorized to obtain and discuss medical, treatment, therapy, financial, and other information relating to applicant with the applicant's healthcare providers, pharmacy, employer, insurance company, and/or any other person or entity working with BVLT on the applicant's behalf for purposes of confirming the applicant's eligibility for the Financial Assistance Program. BVLT may also use or disclose the applicant's personal information as necessary for BVLT to provide applicants with assistance under the program. BVLT may anonymize and deidentify applicant information and data and use such information for BVLT's own purposes, including to develop aggregate reports. Neither BVLT nor any of its employees or agents will disclose any applicant identifiable information to any third party except as provided above, as required by law, or as deemed appropriate by BVLT to investigate or resolve any potential fraud or audit irregularity.

For assistance with the application or for more information, contact Felita at 404-454-1438 or admin@bettieandvera.org

ASSISTANCE PROGRAM APPLICATION

APPLICANT INFORMATION

First Name:_______________________________________ Date of Application: ________________

Street Address: ____

City/State/Zip Code: ____ ________

Phone Number: ______________________ eMail Address: _________________________________

Date of Birth: _________________________

Reason for Application:____

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ASSISTANCE NEEDED

(Please select the most urgent care related need):

☐ Rent/Housing ☐ Utilities or Bills ☐ Food/Groceries ☐ Auto loan or insurance ☐ Home Health Care

☐ Oral Treatment Medication (e.g. Chemotherapy, Hormone Therapy, etc.) ☐ Elder Care

☐ Side-effect Management Medication (e.g. Pain, Anti-nausea, etc.) ☐ Child Care

PHOTO RELEASE

The information in this section will not be used to determine eligibility

I, ___________________, grant permission and give my consent to The Bette Lott and Vera Times Foundation the use of photograph(s) or electronic media image taken as part of presentation.

☐ Yes, I give my consent ☐ No, I do not give my consent

PAYMENT INFORMATION

☐ Zelle (Preferred) ☐ Mailed Check ☐ Direct Deposit (BVLT will contact you for your bank account information)

Zelle eMail or Phone#: ___________________________

Address for mailed check: ____

ASSISTANCE PROGRAM APPLICATION

MEDICAL VERIFICATION (Please Do Not Send Official Medical Records)

Name of patient: ____

Type of cancer: _____________________________________ Date of diagnosis (Month/Year): ____________

Please provide information about treatment below:

Chemotherapy	Radiation	Hormone Therapy	Surgery
Start date: ________	Start date: ________	Start date: _________	Start date: _________
End date: _________	End date: _________	End date: __________	

If patient is not receiving active treatment, is he/she receiving follow up care? ☐ Yes ☐ No

Oncologist: ___________________________ Practice/Facility/Hospital: ___________________________

Practices or treatment facilities with multiple locations – which location? ___________________________

I affirm the diagnosis and treatment information in this application and have no reservations concerning this patient's request for financial assistance from The Bettie Lott and Vera Times Foundation because of cancer-related financial toxicity.

Oncologist Signature: ____ Date: ________________

I, ____, hereby attest that the information provided in this application is true, accurate and complete and that I am the person who is the subject of the application or have been authorized by the applicant to act on his/her behalf. By signing below, I further attest that I have read and understand the Terms & Conditions and Privacy Policy of the BVLT Assistance Program. By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

I authorize my healthcare provider(s) to release information to BLVT related to this application. I understand that information provided to BLVT will remain confidential, except that BLVT may disclose information to my creditors and others as may be necessary to provide financial assistance. I understand that I remain fully responsible for timely payments of my debts, and indemnify and hold harmless BLVT for any expenses, losses or liabilities arising from or related to my debts.

If not applicant: First name: __________________________Last name: _______________________ Relationship to applicant: ☐ Parent or Guardian ☐ Spouse or Partner ☐ Family Member ☐ Social Worker ☐ Patient Navigator ☐ Healthcare Provider ☐ Other (please specify): ____

Signature*: _______________________________________Date*: __________________________

The Bettie Lott and Vera Time Foundation | 404-454-1438 | admin@bettieandvera.org