THE DOVE FUND

We know a patient's share of medical costs related to breast cancer treatment can be overwhelming and may become a barrier to getting well. That is why Overcomers created this new co-pay relief program. Thanks to many gracious donors, we are now able to help qualified women with out-of-pocket co-pays, co-insurance and deductibles related to their breast cancer treatment.

PRE-QUALIFICATION: Answer the following questions to see if you qualify.

(circle one)

Are you a female who has been diagnosed with breast cancer? (a physician and pathology report will be required)	YES NO
Are you currently undergoing, or about to start, ***active treatment*** for breast cancer? Overcomers defines active treatment as the period after a positive diagnosis of breast cancer has been made, and during which therapies are being administered, including related radiology staging studies, mediport placement, surgical procedures to remove cancer (e.g. single/double mastectomy, lumpectomy, axillary dissection) or biopsy lymph node(s), chemotherapy (oral and/or by infusion), immunotherapy, radiation, or stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment. Receiving ONLY long-term hormone therapy is NOT considered "active treatment."	YES NO
Do you currently have a treatment plan in place with a physician?	YES NO
Does your treatment plan **include treatments *other than*** tamoxifen, anastrozole (Arimidex®), letrozole (Femera®), exemestane (Aromasin®) and/or ovarian suppression?	YES NO
Is the treatment plan being administered in the United States?	YES NO
Do you currently have health insurance (any type)?	YES NO
Are you a citizen or permanent resident of the United States?	YES NO
Do you reside in one of the following counties in the state of Texas: Bexar, Comal, Guadalupe, Kendall or Wilson?	YES NO
Do you have verifiable *household* income that falls at or below 300% of the Federal Poverty Guidelines? Use the chart below to calculate. Number of people in your household: _____ (*include yourself*) Corresponding maximum income limit: $_____ (*from table*) Example: Number of people in household: 6 300% above Federal Poverty Guideline $ 106,740 All household income will need to be verified during the application process – see page 6 of application for additional information.	YES NO

Persons in Household	300% Above Federal Poverty Guideline
1	$38,640
2	$52,260
3	$65,880
4	$79,500
5	$93,120
6	$106,740
7	$120,360
8	$133,980
For each person over 8, add:	$13,620

* Source: US Dept of Health and Human Services, 1/26/21

We invite you to apply if you answered "YES" to ***all*** the above questions.
Please see the attached for more information.

HOW THE DOVE FUND WORKS

The Dove Fund is designed to help qualified women with a portion of their co-pays, co-insurance and/or deductibles directly related to eligible breast cancer treatments. Applicants can receive a benefit of up to $1,000 per calendar year, based on qualifications, available funding, and ability to demonstrate financial need. The Dove Fund is not an emergency fund and cannot provide immediate financial assistance. This is how our program works:

1. **YOU COMPLETE AND SIGN THE APPLICATION**
   We require a significant amount of documentation to ensure you are eligible for support. You will need to coordinate with both your healthcare provider or medical facility and their billing department to complete the application. It will take time to compile, complete and mail using US Postal Service. Since applications are only accepted during one week in May and one week in November (see below), plan carefully so due dates don't pass you by.

2. **YOU MAIL YOUR APPLICATION**
   All applications must be *MAILED* to: **Overcomers P.O. Box 172 La Vernia, TX 78121** and *postmarked between the 12th and the19th of July*. Applications postmarked outside those dates will not be considered for financial assistance. Please note we are unable to provide confirmation of receipt for any submissions.

3. **WE REVIEW APPLICATIONS**
   Applications are reviewed on a *first-come, first-served basis*. The Dove Fund representatives will carefully review your application to make sure you meet all eligibility requirements, that the application is complete, and that all requested documents are submitted. Incomplete, unsigned or late applications will not be considered.

   Review of all applications will be completed no later than the 25th day of July.

4. **WE APPROVE GRANT AWARDS AND NOTIFY RECIPIENTS**
   Applicants who receive assistance will be notified by email no later than the 27th of July. A letter by mail will also be sent to grant recipients. We will send payment directly to a healthcare provider or medical facility on your behalf.

5. **WE SEND PAYMENT TO HEALTHCARE PROVIDER/FACILITY**
   Assistance for applicants receiving a grant *will be mailed directly to the designated healthcare provider or medical facility* on your behalf. At no time will payment be sent directly to the applicant. Payments will be mailed no later than the last day of the month in which funding was approved.

ELIGIBLE APPLICANTS

The Dove Fund considers applications from those who meet the following requirements:

- Is a female who has been diagnosed with breast cancer, and
- Is currently undergoing, or is about to start, *active treatment** for breast cancer, and
- Has a treatment plan and care team in place prior to applying for assistance, and
- Is a US citizen or permanent resident of the United States, and
- Resides in Bexar, Comal, Guadalupe, Kendall or Wilson counties located in Texas, and
- Currently has health insurance (private, government, COBRA, etc.), and
- Verifiable household income that falls at or below 300% of the Federal Poverty Guidelines, and
- Insufficient resources from cash, bank accounts, and investments to pay patient's share.

If you cannot demonstrate that you meet all the above requirements during the application process, you do not qualify for assistance from The Dove Fund.

COSTS ELIGIBLE FOR ASSISTANCE

The Dove Fund helps eligible women with a portion of their patient co-pays, co-insurance and deductibles related to certain therapies administered during *active treatment** of their breast cancer.

Therapies eligible for assistance include:

- Radiology staging studies following positive diagnosis of breast cancer,
- Mediport placement,
- Surgical procedures to remove cancer (e.g. single or double mastectomy, lumpectomy, axillary dissection) or biopsy lymph node(s),
- Chemotherapy (oral and/or by infusion)*,
- Immunotherapy,
- Radiation,
- Stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment.

We **cannot** assist in any of the following:

- Treatments administered outside the United States,
- Treatments not approved by the FDA for treatment of breast cancer,
- Long-term hormone (tamoxifen, letrozole, etc.), if it is currently your *ONLY* treatment,
- Costs for any medication, over the counter or prescribed, that are not dispensed by the healthcare provider or medical facility administering your eligible breast cancer therapies,
- The termination of any pregnancy by any method even if prescribed by a physician.

** Overcomers defines active treatment as the period after a positive diagnosis of breast cancer has been made, and during which therapies are being administered, including related radiology staging studies, mediport placement, surgical procedures to remove cancer (e.g. single/double mastectomy, lumpectomy, axillary dissection) or biopsy lymph node(s), chemotherapy (oral and/or by infusion), immunotherapy, radiation or stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment. Receiving ONLY long-term hormone therapy is NOT considered "active treatment" for purposes of this program.*

THE APPLICATION PROCESS

Our application requires a significant amount of information from you and your treating physician. The application will take time to gather, compile, and complete all information. Please plan accordingly and start compiling early so due dates don't pass you by.

The application will require you to designate, and coordinate with, one healthcare provider or medical facility to receive payment (if awarded) on your behalf. This provider or medical facility is required to be on the care team administering ACTIVE treatment for your breast cancer. You will also need to work with your provider's billing department to obtain information to include in your application package.

Application Due Dates

Applications:

- are accepted during two Acceptance Periods per calendar year. The current acceptance period is July 12th – July 19th.
- are ONLY accepted by US Mail.
- are reviewed on a first-come, first-served basis.
- postmarked before the 1st or after the 7th of each Acceptance Period will not be reviewed and will NOT be held over to the next application period.

Reapplying for Assistance

Overcomers makes every effort to grant assistance when needed, however, the program is limited by available resources and not all qualified requests can be granted. We invite you to reapply as follows:

Applicants Who Do Not Receive Assistance

Reapply in any following application period by sending a new application in full, with updated documentation. You must meet all program requirements currently in place at the time of application. Incomplete applications will not be considered.

Applicants Who Receive Assistance

You must wait 18 months before again requesting assistance. Reapply by sending a new application in full, with updated documentation. You must meet all program requirements currently in place at the time of application. Incomplete applications will not be considered.

Acceptable Documentation

Guidance is provided below as to what documents will be accepted for select items on the application.

Applicant Information		
Proof of US Citizenship:	Copy of U.S. passport, **OR** Copy of your U.S. birth certificate, **OR** Consular Report of birth Abroad or Certification of Birth, **OR** Certificate of Naturalization, **OR** Certificate of Citizenship.	
Proof of US Alien Registration	Copy of your immigration or naturalization documents (e.g. Green Card)	
Request for Co-Pay Assistance		
Evidence of Unpaid Medical Balance	Invoice issued by provider receiving payment **OR** Patient financial responsibility form prepared by the provider	**AND** Patient ledger showing payments made to date toward treatments
Income Sources		
Wages	3 months paystubs or salary history and/or salary verification letter from employer	
Public assistance	Copy of letter from the government agency administering the program which states monthly amount awarded and period over which assistance will be paid.	
Social security	Statement of social security benefits (***Include***: copy of award letter, check or recent bank statement indicating monthly benefit amount)	
Unemployment comp.	Statement of unemployment benefits	
Workers comp.	Workers Compensation Benefit	
Short-term disability	Statement of short-term disability benefits award letter	
Long-term disability	Statement of long-term disability benefits award letter	
Alimony	Statement of Alimony Support received	
Child Support	Statement of child support received	
Military Entitlements	Most recent 3 months of LES forms	
Retirement Pay/Pensions	Statement of pension or retirement benefits	
Other income (rent/dividends)	Support showing nature, amount, and how often the income is received (e.g. bank statements, etc.)	

FINAL CHECKLIST

Please use the following checklist to make sure you've included all required information in your application package. Incomplete applications will not be reviewed.

Include the following in your application package:

☐	Application (all seven pages)
☐	Physician Verification Form completed and signed by your Surgeon, Oncologist, Licensed Social Worker, or Nurse Navigator
☐	Copy of "Patient Authorization to Use or Release Protected Health Information" form signed by applicant and sent to the physician or healthcare representative completing the Physician Verification Form.
☐	Copy of pathology report with your name showing a positive breast cancer diagnosis (all pages)
☐	Signed "Terms of the Consent Pertaining to the Disclosure of your Personal Information" form
☐	Copy of latest utility bill for your home
☐	Copy of proof of US citizenship or permanent residency status
☐	Evidence of unpaid medical balance at designated healthcare provider or medical facility
☐	Copy of health insurance card(s) – both front and back
☐	Copy of your most recently filed federal tax return
☐	Proof of income documents supporting *all* sources of *household* income (see page 5 for guidance)
☐	Copies of the two most recent bank statements for each account listed
☐	Application is signed
☐	All application sections are complete
☐	A copy of the application package, including all pages and supporting documents, has been made for your files. We will not return any submitted documents after application review.

Once the above items are added, you are ready to mail your package.

MAIL TO: **Overcomers: Daughters of the King of Kings**
P.O. Box 172
La Vernia, TX 78121

All completed application packets must be postmarked ***between the 12th and the 19th of July 2021.*** Packages postmarked outside those dates will not be considered.

Questions? Email us at thedovefund@overcomersbreastcancer.com

THE DOVE FUND

APPLICATION FOR ASSISTANCE

APPLICANT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE INITIAL)			FOR APPLICATION PERIOD **JULY 2021**
STREET ADDRESS			
CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE
PHONE NUMBER (INCL. AREA CODE)		SECONDARY PHONE (INCL. AREA CODE)	
EMAIL	DATE OF BIRTH	SSN OR ALIEN NUMBER	

****ATTACH: COPY OF MOST RECENT UTILITY BILL AND PROOF OF U.S. CITIZENSHIP OR ALIEN REGISTRATION****

EMERGENCY CONTACT

FULL NAME (FIRST AND LAST)	PHONE	RELATION

AUTHORIZED PERSON

IS ANYONE AUTHORIZED TO SPEAK TO OVERCOMERS ON YOUR BEHALF YES NO ***(IF "YES", COMPLETE THE FOLLOWING)***

FIRST NAME	LAST NAME	RELATIONSHIP

SPECIAL AUTHORIZATION (IF ANY)	PHONE NUMBER (INCL. AREA CODE)

MEDICAL INFORMATION

CANCER DIAGNOSIS (INCL. TYPE: TRIPLE NEGATIVE, ER/PR+, HER2-, ETC.)	DATE OF DIAGNOSIS	ARE YOU CURRENTLY IN <u>ACTIVE</u> TREATMENT?* YES NO

COMPLETED TREATMENT(S) – CIRCLE ALL THAT APPLY

SURGERY: MASTECTOMY LUMPECTOMY AXILLARY DISSECTION DATE(S): _____

CHEMO: START DATE _____ END DATE: _____ **RADIATION:** START DATE _____ END DATE: _____

LYMPH NODE BIOPSY: DATE _____

TREATMENT(S) IN PROCESS OR NOT YET RECEIVED – CIRCLE ALL THAT APPLY

SURGERY: MASTECTOMY LUMPECTOMY AXILLARY DISSECTION OTHER: _____

CHEMO: ANTICIPATED START DATE _____ ANTICIPATED END DATE: _____ (IF KNOWN)

RADIATION: ANTICIPATED START DATE _____ ANTICIPATED END DATE: _____ (IF KNOWN)

** Overcomers defines active treatment as the period after a positive diagnosis of breast cancer has been made, and during which therapies are being administered, including related radiology staging studies, mediport placement, surgical procedures to remove cancer (e.g. single/double mastectomy, lumpectomy, axillary dissection) or biopsy of lymph node(s), chemotherapy (oral and/or by infusion), immunotherapy, radiation or stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment. Receiving ONLY long-term hormone therapy is NOT considered "active treatment" for purposes of this program.*

TREATING PHYSICIAN AND/OR TREATMENT FACILITY

(THE PROVIDER TO WHICH YOU REQUEST FINANCIAL ASSISTANCE BE SENT)

TREATING PHYSICIAN NAME	FACILITY NAME

PHYSICAL ADDRESS

BILLING POINT OF CONTACT

FIRST AND LAST NAME	EMAIL (IF KNOWN)

MEDICAL PROVIDER'S TAX PAYOR IDENTIFICATION NUMBER

PAYMENT REMITTANCE ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS ABOVE)

CITY	STATE	ZIP CODE	PHONE NUMBER

REQUEST FOR CO-PAY ASSISTANCE

AMOUNT REQUESTED (CANNOT EXCEED $1,000)	TYPE OF ASSISTANCE REQUESTED (CIRCLE ALL THAT APPLY)
$_____	CO-PAY CO-INSURANCE DEDUCTIBLE

****ATTACH COPY OF THE UNPAID INVOICE TOWARD WHICH YOU ARE REQUESTING PAYMENT****

HEALTH INSURANCE

ARE YOU CURRENTLY COVERED BY ANY TYPE OF HEALTH INSURANCE?	DO YOU HAVE SECONDARY COVERAGE?
YES NO	YES NO

COMPLETE THE FOLLOWING INFORMATION ABOUT YOUR COVERAGE

	PRIMARY	SECONDARY (IF APPLICABLE)
INSURANCE CARRIER	_____	_____
ANNUAL DEDUCTIBLE UNDER PLAN:		
AMOUNT	$ _____	$ _____
HAVE YOU REACHED YOUR DEDUCTIBLE?	YES / NO	YES / NO
ANNUAL MAXIMUM OUT-OF-POCKET UNDER PLAN:		
AMOUNT	$ _____	$ _____
HAVE YOU REACHED THE MAX OUT-OF-POCKET?	YES / NO	YES / NO
CO-PAY OR CO-INSURANCE FOR MEDICAL SERVICES	$ _____	$ _____

ARE TREATMENTS FOR WHICH YOU ARE REQUESTING ASSISTANCE COVERED UNDER YOUR INSURANCE PLAN? (CIRCLE ONE) YES PARTIALLY NO

****ATTACH COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD(S)****

FINANCIAL INFORMATION

THE TAX YEAR OF YOUR MOST RECENTLY FILED FEDERAL TAX RETURN (CIRCLE ONE):	***IF YOUR ANNUAL INCOME CHANGED SIGNIFICANTLY FROM THE INCOME SHOWN ON THE REFERENCED TAX RETURN, EXPLAIN CHANGES IN AMOUNTS AND REASON(S) FOR CHANGE. (OTHERWISE LEAVE BLANK)***
2019 2020	_____
ARE YOU CURRENTLY ACTIVELY EMPLOYED?	_____
YES NO	_____

****ATTACH COPY OF SIGNED FEDERAL TAX RETURN FOR MOST RECENT YEAR (PAGES 1 AND 2 ONLY)****

USE THIS TABLE TO TELL US ABOUT ALL OF YOUR INCOME SOURCES FOR THE YEAR. PLEASE NOTE:

- ***AMOUNTS SHOULD REFLECT TOTAL <u>HOUSEHOLD</u> INCOME RECEIVED FOR AN ENTIRE YEAR (12 MONTHS), AND***
- ***DOCUMENTS FOR PROOF OF INCOME ARE REQUIRED WITH YOUR APPLICATION. SEE PAGE 5 FOR GUIDANCE ON WHAT TYPE OF DOCUMENTS ARE ACCEPTED.***

ANNUAL INCOME SOURCES	**SELF (A)**	**SPOUSE OR OTHER (B)**	**TOTAL HOUSEHOLD INCOME (A + B)**
Wages	$	$	$
Self-Employment			
Public Assistance			
Social Security			
Unemployment Comp.			
Workmen's Comp.			
Short term disability benefits (began: _____ End: _____)			
Long term disability benefits (began: End:)			
Alimony			
Child Support			
Military Entitlements (include BAS/BAH/other)			
Retirement Pay/Pensions			
Other Income (rent/dividends)			
TOTAL	$	$	$

(FINANCIAL INFORMATION CONTINUED ON NEXT PAGE)

DO YOU OR YOUR SPOUSE/SIGNIFICANT OTHER HAVE ANY BANK ACCOUNTS, INVESTMENT ACCOUNTS, RETIREMENT ACCOUNTS OR CASH ON HAND (CIRCLE ONE)? *YES NO*

IF "YES", USE THIS TABLE TO LIST ALL OPEN ACCOUNTS AND ATTACH COPIES OF THE TWO MOST RECENT STATEMENTS. INCLUDE ACCOUNTS OF YOUR SPOUSE/SIGNIFICANT OTHER IF YOU LIVE IN THE SAME HOUSEHOLD.

NAME OF FINANCIAL INSTITUTION	ACCOUNT TYPE (CKG, SVGS, INVEST, RETIRE, OTHER)	ENDING BALANCE ON MOST RECENT STATEMENT	DATE OF MOST RECENT STATEMENT (MO/DAY/YR)
		$	
TOTAL OF ALL BANK/ INVESTMENT/RETIREMENT ACCOUNTS		$	

*****DO NOT FORGET TO ATTACH COPIES OF THE TWO MOST RECENT STATEMENTS FOR EACH ACCOUNT LISTED*****

USING THESE TABLES, DOES YOUR ANNUAL HOUSEHOLD INCOME FALL AT OR BELOW 300% OF FEDERAL POVERTY GUIDELINES? (CIRCLE ONE) *YES* *NO*

NUMBER OF HOUSEHOLD DEPENDENTS:

OF ADULTS (INCLUDE YOURSELF) _____

OF CHILDREN UNDER 18 YRS OF AGE _____

OF OTHER (PLEASE SPECIFY) _____

TOTAL NUMBER OF DEPEDENTS IN YOUR HOUSEHOLD _____

Persons in Household	300% Above Federal Poverty Guideline
1	$38,640
2	$52,260
3	$65,880
4	$79,500
5	$93,120
6	$106,740
7	$120,360
8	$133,980
For each person over 8, add:	$13,620

* Source: US Dept of Health and Human Services, 1/26/21

WITHIN THE <u>LAST TWO YEARS</u>, HAVE YOU RECEIVED ANY FINANCIAL ASSISTANCE FROM OTHER AGENCIES OR SUPPORT ORGANIZATIONS TO HELP YOU DURING YOUR BREAST CANCER TREATMENTS? (CIRCLE ONE) *YES* *NO*

IF "YES", PLEASE LIST ALL SUPPORT RECEIVED ON THE TABLE BELOW. INCLUDE THE DOLLAR VALUE OF SUPPORT RECEIVED, IF KNOWN.

NAME OF ORGANIZATION, AGENCY, OR RESOURCE	TYPE OF ASSISTANCE (CO-PAY/UTILITIES, TRANSPORTATION, ETC.)	DATE APPLIED (MO/YEAR)	DOLLER VALUE OF SUPPORT RECEIVED (IF KNOWN)
TOTAL VALUE OF FINANCIAL SUPPORT RECEIVED OVER THE LAST TWO YEARS FOR TREATMENTS			$

TERMS AND CONDITIONS

APPLICATION TERMS AND CONDITIONS

- Applicant understands that the submission of the application and all required supporting documentation does not guarantee an award under the program.
- All applications are accepted on a first-come, first-served basis if funding is available and if application was submitted within the Acceptance Period that corresponds to the application period indicated on the first page of the application.
- Applicant understands the application package must be mailed and postmarked between the 12th and 19th of July, 2021 to be considered.
- Applicant represents that they meet all qualifications to receive assistance from our program.
- Applicant agrees to notify Overcomers: Daughters of the King of Kings if the financial situation, insurance status, or medical conditions change from what has been documented in the application. Failure to do so may result in the applicant's restricted participation in this or any future assistance fund administered by Overcomers.

DIAGNOSIS AND TREATMENT REQUIREMENT

- All applicants must submit an original signed Physician Verification Form that confirms diagnosis, treatment plan, and period over which treatment is, or will be, administered. Failure to provide this documentation will cause applicant to become ineligible for financial support.
- A complete copy of the pathology report showing a positive breast cancer diagnosis must be submitted. All pages of the report must include the patient's name on the report must match that of the applicant.
- Applicant understands that both the treating physician and treatment plan must be in place prior to applying for support.
- Applicant must submit an original signed "Patient Authorization to Use or Release Protected Health Information" form to the treating physician who will be completing the Physician Verification Form. Failure to provide this authorization will delay your physician's completion of required forms.

PROOF OF INCOME AND BANK/INVESMENT ACCOUNT BALANCES

- All applicants are required to provide required documentation to verify current household income and bank and investment account balances. Failure to provide documentation, or those with household income in excess of program guidelines, or those with bank/investment balances more than sufficient enough to pay patient's share of treatment, will not be eligible for any co-pay assistance under this program.

AWARD TERMS AND CONDITIONS

- Any applicant approved for assistance understands that Overcomers only offers financial support to insured patients who financially and medically qualify.
- The financial support provided by the program will be applied toward the applicant's co-pays, co-insurance, and/or deductibles required for the active treatment of breast cancer.
- Financial support will be sent ***directly to the designated healthcare provider or facility*** on the applicant's behalf. Failure to provide accurate payment remittance instructions may result in the forfeiture of any award.
- Applicant understands that Overcomers solely depends on an original unpaid invoice (or patient financial responsibility form) along with patient ledger showing payments to date toward treatments. Both are to be prepared by the designated healthcare provider or facility who will receive payment and both schedules will be used to determine the amount awarded, if any. Failure to submit this documentation will result in applicant ineligibility.
- Applicant understands all billing inquiries, invoicing requests, or general patient account questions are between the applicant and the provider. Overcomers will not represent the applicant, nor negotiate, nor resolve any billing issues with the healthcare provider or facility on the applicant's behalf.
- Applicant understands they are financially responsible for any and all charges not covered by The Dove Fund program.
- Applicant agrees that any refund received from their designated healthcare provider or medical facility, up to the amount(s) awarded through The Dove Fund, must be returned to The Dove Fund. Should this occur, email thedovefund@overcomers.com for submittal instructions.

LIMITATION OF LIABILITY

- Applicant agrees that Overcomers, our sponsors, and our donors shall not be liable for any damages of any kind, without limitation, arising out of or in connection with you receiving financial assistance, co-pay relief, or other value-added benefits or services provided as a part of this program.

MISCELLANEOUS TERMS AND CONDITIONS

- Applicant understands that Overcomers does not discriminate on the basis of race, color, religion, national origin, age or disability.
- Applicant agrees that Overcomers and its donors will not be liable for any damages of any kind, without limitation to the success or failure of cancer treatments, or for any harm that it may cause.
- Applicant agrees that Overcomers is not a medical provider and is not in any way liable for the success or failure of any treatment program that applicant elects to undertake or participate in.

- Applicant understands that Overcomers makes every effort to grant assistance when needed, however, the program is limited by available resources and may be discontinued or changed at any time.
- Applicant further understands that they can change treating physicians or healthcare facilities at any time without affecting their participation in the program provided the applicant continues active treatment, as defined by Overcomers. Funds awarded by The Dove Fund, however, must be submitted to the physician or healthcare facility designated in the application and cannot be redirected to a new care provider.

CERTIFICATION AND SIGNATURE

I hereby **certify that the above statements are true** and correct to the best of my knowledge. I understand that a false statement may disqualify me for assistance.

_____
Name of Applicant (printed)

_____ _____
Signature of Applicant or Patient Representative Date

PATIENT REPRESENTATIVE

If the application was completed by a patient representative, please complete the following:

_____ _____
Patient Representative Phone

_____
Title

OPTIONAL SURVEY

Overcomers would like to publicize The Dove Fund in the appropriate settings so we can reach all breast cancer patients who may benefit from our program. Where did you learn about assistance available through The Dove Fund?

_____

_____

_____

_____

_____

_____

_____

_____

_____

Questions? Email us at thedovefund@overcomersbreastcancer.com

THE DOVE FUND

PHYSICIAN VERIFICATION FORM

This form may be completed by a Surgeon, Oncologist, Licensed Social Worker, or Nurse Navigator

Dear Provider,

Your patient has applied to receive financial support from The Dove Fund, an Overcomer co-pay relief program available to qualified women currently in active treatment* for breast cancer.

For your patient to complete her application package, we must verify the following information with you as the prescribing and/or treating physician. Please complete this form and return a signed original to your patient so it can be included in her application package.

A signed **Patient Authorization to Use or Release Protected Health Information** form is enclosed.

PATIENT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE INITIAL)			
STREET ADDRESS			
CITY		**STATE**	**ZIP CODE**
PHONE NUMBER (INCL. AREA CODE)		**SECONDARY PHONE (INCL. AREA CODE)**	
DATE OF DIAGNOSIS	**CANCER TYPE AND SUB-TYPE**		
IS YOUR PATIENT CURRENTLY IN, OR WILL SOON BEGIN, ACTIVE TREATMENT* ? (CIRCLE ONE)	**YES**	**NO**	
DATE YOUR PATIENT BEGAN ACTIVE TREATMENT (OR WILL BEGIN TREATMENT)			
STAGE AT FIRST DIAGNOSIS	**HAS THE STAGING CHANGED FROM WHEN YOU WERE FIRST DIAGNOSED?** YES NO **IF YES, WHAT IS THE CURRENT STAGE?**		

** Overcomers defines active treatment as the period after a positive diagnosis of breast cancer has been made, and during which therapies are being administered, including related radiology staging studies, mediport placement, surgical procedures to remove cancer (e.g. single/double mastectomy, lumpectomy, axillary dissection) or biopsy of lymph node(s), chemotherapy (oral and/or by infusion), immunotherapy, radiation or stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment. Receiving ONLY long-term hormone therapy is NOT considered "active treatment" for purposes of this program.*

(continued)

PRESCRIBING PHYSICIAN:

FULL NAME			
BUSINESS ADDRESS			
CITY	**STATE**	**ZIP CODE**	**LICENSE NUMBER**
PHONE NUMBER (INCL. AREA CODE)		**EMAIL**	
CONTACT PERSON		**TITLE**	**PHONE (IF DIFFERENT FROM ABOVE)**

I certify that I am a Physician, Licensed Social Worker or Nurse Navigator currently working with the above-named patient. I certify that all information provided in the form is true.

I further understand that The Dove Fund helps eligible patients who are currently (or will soon be) undergoing active treatment, as defined by the program, for breast cancer. The Dove Fund will make every effort to grant assistance when needed, however the program is limited by available resources and may be discontinued or changed at any time.

_____ _____

Name of Physician / LSW / Nurse Navigator (printed)

Phone (if other than prescribing physician)

_____

Signature of Physician / LSW / Nurse Navigator

_____

Date

THANK YOU FOR YOUR COOPERATION

Overcomers: Daughters of the King of Kings is a 501(c)(3) non-profit organization and a sisterhood for breast cancer survivors. Our mission is to be real in sharing our needs, build strong foundational relationships and walk out our journey in victory serving others in our circle of influence. Together we can rebuild lives one piece at a time.

NOTE TO APPLICANT
Submit this completed and signed form to the physician/healthcare provider who will be completing the Physician Verification Form. Also retain a copy of the completed form to include in your application packet.

Patient Authorization to Use or Release Protected Health Information

I authorize the use and disclosure of my individual identifiable health information ("Protected Health Information") to ***Overcomers: Daughters of the King of Kings, a breast cancer non-profit Texas organization ("Overcomers")***. This information is needed to process my application for The Dove Fund, a charitable patient assistance relief program that may help me with a some of my co-payments, co-insurance and/or deductible.

I authorize the following physician/medical information institution to release information:

_____

_____

_____

(include practice name and address)

I authorize my medical provider to disclose to ***Overcomers*** my health information verbally or written to be used for the purpose stated above. I further authorize disclosure of any billing information verbally or written to be used for the purpose state above. I understand that my Protected Health Information may be subject to re-disclosure pursuant to this authorization. I may withdraw this authorization by mailing or e-mailing a letter of revocation to Overcomers, but if I do, it will not influence any actions Overcomers took before it received revocation of the authorization. If I revoke this authorization, I will no longer be eligible to receive assistance from Overcomers through this program.

This authorization expires on: _____

Printed Name of Patient:_____

Date of Birth: _____

By signing this document, I agree that all the information provided is truthful and accurate to the best of my knowledge. I understand that the application for assistance does not guarantee funding will be available. I understand that if I am awarded financial assistance that I must re-apply and provide updated income information. There is never a guarantee that funding will be available.

Signature of Patient: _____ Date: _____

Terms of the Consent Pertaining to the Disclosure of your Personal Information

For you to receive assistance through Overcomers: Daughters of the King of Kings ("Overcomers"), you authorize your physicians, pharmacies, and insurance companies to disclose to Overcomers and its applicable contractors, employees, agents and other representatives your personal information. In addition, you authorize Overcomers to use and disclose your personal information to Overcomers' agents, third parties acting on its behalf, or any of your healthcare providers.

Your personal information may include, but not be limited to, your name, address, phone number, email address, date of birth, social security number, insurance status and numbers, amount of financial assistance allocated and dispensed, diagnosis information, and treatment information.

You consent to the disclosure of your personal information for the following purposes: (i) to enable Overcomers to determine whether you are eligible and qualify for financial assistance; (ii) to enable Overcomers to provide financial assistance to you; (iii) to refer you to, or to determine your eligibility for other programs, foundations or alternate sources of funding or coverage for your healthcare costs, products and services; (iv) to facilitate the audit or review of Overcomers' operations; and (v) to enable Overcomers to manage its patient assistance programs.

Although Overcomers intends to handle your personal information with due care, you understand that your personal information that is disclosed may be re-disclosed by the recipient and is no longer protected by federal or state privacy regulations and laws. You consent to Overcomers re-validating your personal information. You consent to Overcomers electronically disclosing your personal information to third parties as permitted or required by law.

You may revoke this consent at any time by mailing a signed letter of revocation to Overcomers' Privacy Officer in c/o Overcomers at P.O Box 172 La Vernia, TX 78121. Revoking this consent will not have any effect on actions that Overcomers took in reliance on the consent before it received notice of your revocation. If you revoke this consent, you will not be able to receive future assistance through Overcomers. However, your applicable healthcare providers and insurance companies, who are disclosing the information to Overcomers, may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this consent.

This consent expires six years from the date that you last receive assistance from Overcomers, if not revoked sooner.

_____	_____
Signature of Individual or Individual's representative	Date
_____	_____
Print name of Individual's representative: (If applicable)	Authorized Relationship or Authority to Act (If applicable)