The Dove Fund
OVERCOMERS

FINAL CHECKLIST

Use this checklist to make sure all required information is submitted. Incomplete applications will not be reviewed. Separate instructions are also available to help you complete the application.

ENCLOSE THE FOLLOWING:

☐	Signed Application (all six 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 (selected page(s) **MUST** show your name, date, diagnosis, and facility issuing the report)
☐	Copy of latest utility bill for your home
☐	Copy of proof of US citizenship or permanent residency status (see page 6 of instructions for list of acceptable documents)
☐	Copy of health insurance card(s) – both front and back
☐	Copy of your most recently filed federal tax return (***please black out any SSNs***)
☐	Proof of income documents supporting *all* sources of *household* income (see Page 6 of Instructions for list of acceptable documents)
☐	***Optional*** documentation showing insurance premiums if coverage is obtained from the marketplace or if self-employed (this may decrease the household income on which your eligibility is determined)
☐	***Optional*** For high-deductible plans – a "Summary of Benefits and Coverage" schedule from your health plan showing all individual/family deductibles and out-of-pocket limits

DOUBLE CHECK THE FOLLOWING:

☐	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 and will retain only the minimal information necessary to administer the fund.

Applications will only be accepted ***BY FAX***.

1. Send all required pages and attachments to **Overcomers: Daughter of the King of Kings to fax 1-210-352-9479**. You will need to confirm all pages were fully transmitted as intended. The transmission report date and time will be the day your file is considered received.
2. Fax services may be available at your physician's office, or at business service centers (e.g. Fed Ex, UPS Store, HEB, etc.)
3. Applications will be reviewed in the earliest review period following the submission of the application.
4. Application reviews will take place in March 2025, July 2025 and November 2025.
5. Applicants will be notified by the end of the review period month. For example, applicants will be notified by March 31, 2025 if their application is reviewed in March 2025.

The Dove Fund
OVERCOMERS

APPLICATION FOR ASSISTANCE

APPLICANT INFORMATION

FULL NAME (LAST, FIRST, MIDDLE INITIAL)			FOR APPLICATION PERIOD **2025**
STREET ADDRESS			
CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE
PHONE NUMBER (INCL. AREA CODE)		SECONDARY PHONE (INCL. AREA CODE)	
EMAIL		DATE OF BIRTH	

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

OTHER APPLICANT INFORMATION

HAVE YOU PREVIOUSLY APPLIED FOR AND *RECEIVED* A DOVE FUND GRANT AWARD IN THE PAST? ☐ YES ☐ NO

IF NO, SKIP THIS QUESTION.

IF YES, WHEN DID YOU RECEVIE THE GRANT (MONTH/YEAR, IF KNOWN)? _____

Private and confidential when completed

MEDICAL INFORMATION

CANCER DIAGNOSIS (INCL. TYPE: TRIPLE NEGATIVE, ER/PR+, HER2-, ETC.)	DATE OF DIAGNOSIS	ARE YOU CURRENTLY IN, OR ABOUT TO START ACTIVE TREATMENT*, OR HAVE OUTSTANDING BILLS RELATED TO ACTIVE TREATMENT* COMPLETED IN THE LAST FOUR MONTHS? ☐ YES ☐ NO

COMPLETED TREATMENT(S) – CIRCLE ALL THAT APPLY

SURGERY: MASTECTOMY LUMPECTOMY AXILLARY DISSECTION **CHEMO** **RADIATION** **LYMPH NODE BIOPSY**

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

SURGERY: MASTECTOMY LUMPECTOMY AXILLARY DISSECTION **CHEMO** **RADIATION** **LYMPH NODE BIOPSY**

****ATTACH: COPY PAGE OF PATHOLOGY REPORT SHOWING YOUR NAME, DIAGNOSIS, REPORT DATE, AND FACILITY ISSUING THE REPORT****

** For purposes of this program, Overcomers defines "**active treatment**" as:*

The period after a breast cancer diagnosis when related therapies are being administered. Those therapies include 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, targeted drug therapy (e.g. Ibrance, Enhertu, etc.), radiation, or stage 1 breast reconstruction in conjunction with a mastectomy or immediately following breast cancer treatment. Receiving ONLY long-term hormone therapy (Tamoxifen or aromatase inhibitors) 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 AT MEDICAL PROVIDER/TREATMENT FACILITY RECEIVING PAYMENT

FIRST AND LAST NAME			EMAIL (IF KNOWN)
CITY	STATE	ZIP CODE	PHONE NUMBER

MEDICAL PROVIDER'S TAX PAYOR IDENTIFICATION NUMBER (IF KNOWN)

PAYMENT REMITTANCE ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS ABOVE)

HEALTH INSURANCE

ARE YOU CURRENTLY COVERED BY ANY TYPE OF HEALTH INSURANCE? YES NO

IF NO, YOU CURRENTLY DO NOT QUALIFY FOR PATIENT ASSISTANCE FROM THE DOVE FUND.

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

FINANCIAL INFORMATION

IMPORTANT

ATTACH AN ADDITIONAL PAGE OF EXPLANATION IF THE EXPECTED INCOME FOR THE CURRENT YEAR HAS SIGNIFICANTLY CHANGED FROM THE INCOME SHOWN ON THE REFERENCED TAX RETURN. INCLUDE REASONS FOR THE CHANGE AND ANY OTHER INFORMATION YOU FEEL BEST EXPLAINS YOUR CURRENT INCOME SITUATION.

ARE YOU CURRENTLY ACTIVELY EMPLOYED?

YES NO

**ATTACH COPY OF SIGNED FEDERAL TAX RETURN FOR MOST RECENT YEAR (PAGES 1 AND 2 ONLY)
PLEASE BLACK OUT SOCIAL SECURITY NUMBERS ON THE FORMS**

REFER TO PAGE 4 OF THE INSTRUCTIONS TO DETERMINE WHAT TO INCLUDE OR EXCLUDE FROM ANNUAL HOUSEHOLD INCOME FOR PURPOSES OF THIS PROGRAM.

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 ADULT CHILDREN
(*if you can claim them as dependent on your tax return*) _____

OF CHILDREN UNDER 18 YRS OF AGE _____

OF OTHER
(PLEASE SPECIFY IN THE SPACE BELOW) _____

TOTAL NUMBER OF DEPEDENTS IN YOUR HOUSEHOLD _____

Persons in Household	300% Above Federal Poverty Guideline
1	$45,186
2	$61,320
3	$77,460
4	$93,600
5	$109,740
6	$125,880
7	$142,020
8	$158,160
For each person over 8, add:	$5,380

* Source: US Dept of Health and Human Services, January 19, 2023

THE NUMBER OF DEPENDENTS IN YOUR HOUSEHOLD SHOULD MATCH THE NUMBER OF DEPENDENTS CLAIMED ON YOUR INCOME TAX RETURN. IF YOU ARE UNSURE WHO QUALIFIES AS YOUR DEPENDENT, PLEASE REFER TO PAGES 17 – 22 IN THE IRS PUBLICATION I1040 HTTPS://WWW.IRS.GOV/PUB/IRS-PDF/I1040GI.PDF

IMPORTANT: IF YOU LIST "OTHER" DEPENDENT(S) ABOVE, PLEASE USE THIS SPACE TO EXPLAIN WHY EACH INDIVIDUAL QUALIFIES AS YOUR DEPENDENT BASED ON THE IRS LINK PROVIDED ABOVE.

THIS PAGE MUST BE RETURNED

Private and confidential when completed

THIS PAGE MUST BE RETURNED

Private and confidential when completed

USE THIS TABLE TO TELL US ABOUT ALL OF YOUR ANNUAL INCOME SOURCES (NOT MONTHLY) EXPECTED FOR THE CURRENT TAX YEAR (CALENDAR 2023).

PLEASE NOTE:

- ***AMOUNTS SHOULD REFLECT TOTAL HOUSEHOLD INCOME EXPECTED TO BE RECEIVED FOR THE ENTIRE YEAR (12 MONTHS), AND***
- ***DOCUMENTS FOR PROOF OF INCOME ARE REQUIRED WITH YOUR APPLICATION. SEE PAGE 4 IN THE INSTRUCTIONS FOR GUIDANCE ON WHAT DOCUMENTS ARE ACCEPTED.***

ANNUAL INCOME SOURCES	SELF	SPOUSE OR OTHER
Wages	$	$
Self-Employment		
Public Assistance		
Social Security		
Unemployment Comp.		
Workmen's Comp.		
Short term disability benefits (began: _____ End: _____)		
Long term disability benefits (began: _____ End: _____)		
Military Entitlements (include BAS/BAH/other)		
Retirement Pay/Pensions		
Income from dividends, interest, and rent		
Any other income (please specify)		

DO YOU HAVE PERSONAL/HOUSEHOLD SAVINGS, OR PERSONAL/HOUSEHOLD INVESTMENT ACCOUNTS AVAILABLE TO HELP MEET YOUR MEDICAL COST OBLIGATIONS? *YES NO*

DUE TO LIMITED FUNDING, IT IS OUR HOPE TO AWARD GRANTS TO THOSE WHO HAVE THE GREATEST FINANCIAL NEED. IF YOU HAVE PERSONAL/ RETIREMENT/ OR HOUSEHOLD SAVINGS, PLEASE FIRST CONSIDER USING THOSE FUNDS PRIOR TO APPLYING FOR THIS GRANT.

OPTIONAL INFORMATION FOR THE SELF-EMPLOYED OR 1099-EMPLOYEE

ARE YOU SELF-EMPLOYED OR A 1099 EMPLOYEE? ☐ YES ☐ NO

IF NO, SKIP THIS SECTION.

IF YES, DO YOU PURCHASE ANY HEALTH/DENTAL/VISION INSURANCE FROM THE MARKETPLACE? ☐ YES ☐ NO

IF YES, ATTACHING A LETTER FROM YOUR INSURER LISTING PREMIUM(S) AND PROOF OF PAYMENT (E.G. BANK STATEMENT, DEDUCTION FROM SOCIAL SECURITY, ETC.) WILL QUALIFY YOU FOR A DECREASE IN ANNUAL HOUSEHOLD INCOME CONSIDERED FOR ELIGIBILITY.

NOTE: THIS OPTIONAL INFORMATION IS NOT NECESSARY IF YOUR HOUSEHOLD ANNUAL INCOME IS WELL BELOW 300% OF THE FEDERAL POVERTY GUIDELINE (SEE PAGE 2) PRIOR TO THIS ADJUSTMENT.

OPTIONAL INFORMATION FOR THOSE WITH A HIGH-DEDUCTIBLE HEALTH PLAN

DO YOUR ANNUAL HEALTH PLAN DEDUCTIBLES EXCEED $1,400/INDIVIDUAL OR $2,800 FOR FAMILY COVERAGE?

☐ YES ☐ NO

IF NO, SKIP THIS QUESTION.

IF YES, A PORTION OF THE DEDUCTIBLES CAN BE USED TO DECREASE THE HOUSEHOLD INCOME ON WHICH YOUR ELIGIBILITY IS DETEREMINED. PROVIDE A CURRENT "SUMMARY OF BENEFITS AND COVERAGE" FROM YOUR HEALTH INSURANCE PLAN TO BE CONSIDERED FOR THIS INCOME ADJUSTMENT.

NOTE: THIS OPTIONAL INFORMATION IS NOT NECESSARY IF YOUR ANNUAL HOUSEHOLD INCOME IS ALREADY WELL BELOW 300% OF THE FEDERAL POVERTY GUIDELINE (SEE PAGE 2) PRIOR TO THIS ADJUSTMENT.

HOW DID YOU HEAR ABOUT US?

PLEASE TELL US HOW YOU HEARD ABOUT OVERCOMERS AND/OR THE DOVE FUND? (SELECT ALL THAT APPLY)

☐ **A MEMBER OF YOUR MEDICAL TEAM (PHYSICIAN / NURSE / SOCIAL WORKER)**

☐ **A BILLING REPRESENTATIVE OR FINANCIAL COUNSELOR AT A MEDICAL OFFICE**

☐ **AN INTERNET SEARCH**

☐ **A PAMPHLET**

☐ **A FRIEND OR WORD OF MOUTH**

☐ **OTHER** _____

TERMS AND CONDITIONS AND PATIENT AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

TO: Overcomers: Daughters of the King of Kings
RE: The Dove Fund

The individual named below (referred to as "I" or "me") desires to participate in The Dove Fund, a financial assistance program (the "Dove Fund" or "Fund") provided by Overcomers: Daughters of the King of Kings ("Overcomers"). In order to be considered for the Fund, I agree to all the terms and conditions set forth in this authorization agreement (this "Authorization"). I understand that signing this Authorization does not guarantee my enrollment in the Dove Fund.

I HEREBY AUTHORIZE THE RELEASE, USE, OR DISCLOSURE OF MY HEALTH INFORMATION AS FOLLOWS:

1. I authorize each and every health care provider providing care to me, and each and every health plan paying or arranging for my care, to disclose and release to Overcomers, and its affiliates and related organizations, any and all of my individually identifiable health information ("Protected Health Information" or "PHI"). The purpose of the disclosure is to allow Overcomers to determine whether I may participate in the Fund, and to otherwise administer my participation in and the overall operations of the Fund and other operations of Overcomers.

2. I further authorize Overcomers to use and disclose my PHI in order to process my application for the Fund and enroll me in the Fund if Overcomers determines I am eligible. I further authorize Overcomers to use and disclose my PHI in order to administer the Fund if I am enrolled.

3. This Authorization shall remain in effect until 50 years after my death, unless revoked as set forth herein.

4. I understand that I may revoke this Authorization at any time by sending a written notification to Overcomers, Attn: The Dove Fund, at P.O. Box 172 La Vernia, TX 78121. The revocation will be effective on the date it has been received and processed by Overcomers. I understand that the revocation does not apply to actions taken by Overcomers in reliance upon this Authorization prior to the effective date of revocation. Upon revocation, I will no longer be eligible to receive assistance through the Fund. I acknowledge that Overcomers will provide me with a copy of this Authorization upon my written request.

5. I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by Overcomers or by any other entity to which Overcomers may disclose such information in the course of administering the Dove Fund.

6. I permit my PHI to be shared with other programs administered by Overcomers: Daughters of the King of Kings why may notify me (by email, phone or USPS mail) of other opportunities and programs available to me and/or my family.

7. I understand I have the right to review and obtain a copy of any of my PHI used and retained by The Dove Fund. Such request may be made in writing to Overcomers, Attn. The Dove Fund, P.O. Box 172 La Vernia, TX 78121. I understand I will be required to pay in advance a reasonable fee to copy and mail the requested records.

8. Should my PHI records used by The Dove Fund be inaccurate, I have the right to correct or amend such records by submitting a written request to Overcomers, Attn. The Dove Fund, P.O. Box 172 La Vernia, TX 78121.

9. I agree that all the information I have provided is truthful and accurate to the best of my knowledge. I understand that my application for assistance does not guarantee my enrollment in the Fund. I understand that if I am enrolled in the Fund, financial assistance will be provided no more than once every twelve months. I know that I must reapply for additional assistance and that there is no guarantee I will be re-enrolled the subsequent year.

10. I also hereby expressly waive and release any and all claims, now known or hereafter known in any jurisdiction throughout the world, against Overcomers, and its officers, directors, employees, agents, affiliates, shareholders, members, agents, representatives, participants, successors, and assigns (collectively, "Releasees"), on account of injury, death, or property damage arising or to arise by reason of or during my participation and/or involvement in the Fund, whether arising out of the negligence of Overcomers or any Releasees or otherwise. I covenant not to make or bring any such claim against Overcomers or any other Releasee, and forever release and discharge Overcomers and all other Releasees from liability under such claims.

11. I agree to notify Overcomers should my household financial situation, health insurance status, or medical condition change before the awarded grant, if any, is fully applied to my medical costs.

12. Other than paying the grant award to my designated provider, I understand Overcomers will not represent me, negotiate, nor resolve any billing issues on my behalf with any healthcare provider or facility. All billing inquiries, invoice requests, or general patient account questions are between me and the provider.

13. I understand the provider receiving payment has **SIX MONTHS** from the date of the grant award letter to present an invoice for payment, and that any unapplied grant funds at the end of this period will be forfeited.

14. I further understand that Overcomers does not retain my information or documentation beyond what is necessary to administer the Fund. If I reapply for the Dove Fund in the future, I understand the application needs to be completed in full as if no information had previously been provided.

15. I understand that both my treating physician and treatment plan must be in place prior to applying for support.

16. I understand that I can change treating physicians or healthcare facilities at any time without affecting my participation in the program provided I continue active treatment, as defined by Overcomers. Should this happen, I am aware that funds already paid to the previous care provider cannot be redirected to my new care provider/facility and the related refund, if any, must be returned to Overcomers.

17. I agree to notify and return to Overcomers any refund received that is directly related to the medical costs paid for by The Dove Fund.

18. I will provide 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. I understand my failure to provide this authorization will delay my physician's completion of required forms.

19. I understand The Dove Fund's primary method of communication is by email. Should I provide an inaccurate or illegible email address, or not respond to grant program emails ***within three weeks*** of its delivery to my inbox, I realize The Dove Fund has the right to redirect my awarded funds to another eligible applicant.

20. This Authorization constitutes the sole and entire agreement of Overcomers and me with respect to the subject matter contained herein and supersedes all prior and contemporaneous understandings, agreements, representations, and warranties, both written and oral, with respect to such subject matter. If any term or provision of this Authorization is invalid, illegal, or unenforceable in any jurisdiction, such invalidity, illegality, or unenforceability shall not affect any other term or provision of this Authorization or invalidate or render unenforceable such term or provision in any other jurisdiction. All matters arising out of or relating to this Authorization shall be governed by and construed in accordance with the internal laws of the State of Texas without giving effect to any choice or conflict of law provision or rule (whether of the State of Texas or any other jurisdiction). Any claim or cause of action arising under this Authorization may be brought only in the federal and state courts located in Bexar County, Texas and I hereby consent to the exclusive jurisdiction of such courts.

CERTIFICATION AND SIGNATURE

BY SIGNING, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTOOD ALL OF THE TERMS OF THIS AUTHORIZATION AND THAT I AM VOLUNTARILY PERMITTING MY HEALTHCARE PROVIDERS AND PAYORS AND OVERCOMERS TO USE AND DISCLOSE MY HEALTH INFORMATION. I ALSO ACKNOWLEDGE THAT I AM GIVING UP SUBSTANTIAL LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE OVERCOMERS.

_____
Name of Applicant (printed)

_____ _____
Signature of Applicant or Patient Representative Date

PATIENT REPRESENTATIVE

If the application was completed by a patient representative, social worker, or nurse navigator, please complete the following:

_____ _____
Patient Representative Phone

_____
Title

PHYSICIAN VERIFICATION FORM

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

Dear Provider,

Your patient has applied for financial support from The Dove Fund, an Overcomer patient assistance fund available to qualified women currently in active treatment* for breast cancer.

For your patient to demonstrate her eligibility, 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 she can include it 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* ? ☐ **YES** ☐ **NO**

IF YES: DATE YOUR PATIENT BEGAN (OR IS EXPECTED TO BEGIN) ACTIVE TREATMENT*? _____

IF NO: HAS YOUR PATIENT COMPLETED ACTIVE TREATMENT* WITHIN THE LAST FOUR MONTHS? ☐ **YES** ☐ **NO**

DATE ACTIVE TREATMENT* WAS COMPLETED (LEAVE BLANK IF NOT APPLICABLE): _____

STAGE AT FIRST DIAGNOSIS	**HAS THE STAGING CHANGED FROM FIRST DIAGNOSIS?** ☐ **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 (Tamoxifen or an aromatase inhibitor) 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 undergoing, soon to begin active treatment for breast cancer, or are within four months after completion of active treatment, as defined by the program.

☐ **By checking this box, I further certify that the treatment(s) for which funding is being requested does not include the termination of any pregnancy by any method even if prescribed.**

I agree the submission of this form does not guarantee funding to my patient since the program is subject to other eligibility requirements and available funding.

_____ _____

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.

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 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 stated 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 not awarded financial assistance during this application period, I must re-apply and provide updated income information. There is never a guarantee that funding will be available.

Signature of Patient: _____ Date: