OvarCare

WE ARE HERE FOR YOU

A CARE PROGRAM FOR OVARIAN CANCER PATIENTS

Ovarcome Non-Profit Inc.

What is OvarCare?

OvarCare is a financial support program offered by Ovarcome Non-Profit Inc. for ovarian cancer patients in active treatment.

At Ovarcome, we are inspired by the simple philosophy of support, love, and celebration of life. Overcoming cancer - celebrating life! We are here to help you as you fight the battle against ovarian cancer. Our care package helps you take care of essentials as you undergo treatment. We also want to make you feel relaxed, peaceful, calm and beautiful. OvarCare is a package especially designed for you – to celebrate the incredibly strong and resilient woman within you.

What does OvarCare offer?

• A Financial grant of $200

• Health restoration consultation at *The Healing Space* by Dr. Monica Roberson– 1 hour (valued at $350). If you'd like to schedule an appointment, please call: 713.520.6800.

• $100 Gas card

• $100 grocery card

• A $50 gift certificate to Cure & Co. – a cancer wellness boutique and spa (where applicable)

Who is it for? OvarCare is designed for you if you:

- Have a diagnosis of ovarian cancer certified by an oncology healthcare provider
- Are in active treatment
- Are a newly diagnosed or existing ovarian cancer patient
- Meet our financial eligibility guidelines of 265% of the Federal Poverty Limits and are able to provide income verification documentation

No. of people in household	Gross Income	Income Verification
1	$30,448	• The first two pages of signed copy of income tax return (SSN not required) - OR - • Copies of your most recent pay stub, unemployment check, or public assistance benefit notification - OR - • If you do not have income: Provide a letter of support from friend or family member
2	$41,077	
3	$51,754	
4	$62,407	

OvarCare Application:

Please apply following the guidelines provided below:

- Initial consultation with a social worker. The social worker will determine your eligibility to receive OvarCare based on the criteria outlined above
- If you are deemed eligible for OvarCare, you will receive our application packet
- You must submit a completed application to be considered for OvarCare. Patients will be selected based on provision of complete information. Unfortunately, we will not be able to process applications with incomplete information
- Signature of receipt must be provided by the patient/authorized family member upon receiving the care package
- If you are unable to receive the package in person, an LOA (letter of authorization) will be required for a family member or friend acknowledging and receiving the package on your behalf
- Please mail in the application at our address below for consideration
- Your physician or social worker must complete all medical information and provide a signature

Apply in 3 steps:

1. Review the application form
2. Fill out the application form and have it verified and approved by your social work counselor
3. Mail or scan the application form and supporting documents to us for to review

Please note:

An application is not a guarantee of receiving OvarCare. Giving will depend on availability of funds.

OVARCOME©

OVERCOMING CANCER ❁ CELEBRATING LIFE!

Ovarcome Non-Profit Inc.

Mailing address:
2525 Robinhood Street, Suite: 203

Houston, TX 77005
Email: info@ovarcome.org facebook.com/ovarcome, twitter.com/ovarcome

OvarCare APPLICATION FORM

UNIQUE APPLICATION NUMBER: _____

PATIENT INFORMATION (please print clearly)

First name: _____ Last name: _____
Date: _____

Address: _____

City, State, Zip: _____ _____

_____

Phone number: Home ( ) _____ Work ( ) _____

Cell ( ) _____

Email Address _____

Date of birth: _____ if patient is a minor (under 18), name of parent or guardian:
_____

Ethnicity:

□ Caucasian

□ African American

□ Latino

□ Asian

□ Other _____

MEDICAL INFORMATION

***** THIS SECTION MUST BE COMPLETED BY**

YOUR ONCOLOGY NURSE, DOCTOR, OR SOCIAL WORKER ONLY ***

Date of diagnosis: _____

Primary cancer: _____

Current Stage:

_____

□ New diagnosis □ Recurrence

Is patient in active treatment? □ Yes □ No

If not in active treatment, indicate frequency of follow-up: □ Yearly □ Bi-Annual □ Other_____

Please indicate type of treatment(s) received in past twelve months (check all that apply)

□ Chemotherapy □ Radiation □ Surgery □ Palliative care

***** PLEASE COMPLETE ALL FIELDS ABOVE*****

HEALTH CARE PROFESSIONAL INFORMATION (please print):

Physician name: _____ Hospital:

_____

Address: _____ City, State, Zip: _____

_____

Phone: ( ) _____ Fax: ( ) _____

PLEASE COMPLETE THIS SECTION TO REQUEST FINANCIAL ASSISTANCE:

1. Name of patient (please print):

_____

2. Do you have health insurance?

□ Yes □ No

3. Are you currently employed?

□ Yes □ No

4. Number of people in your household: _____

5. Please indicate the source of your family income (select all that apply):

□ Salary/compensation

□ Pension

□ Friend/family support

□ Unemployment benefits

□ Short-term disability

□ Other (please specify): _____

□ Annual family income: _____

No. of people in household	Gross Income	Income Verification
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2	$41,077	
3	$51,754	
4	$62,407	

***** Annual family income information must be provided for us to process your application *****

Thank you for your application. We are here to help.

Please note:

We will try our best to provide you with the assistance you need, but giving will depend on the availability of funds. To that extent, an application is not a guarantee of receiving OvarCare.

Ovarcome Non-Profit Inc.

Mailing address:
2525 Robinhood Street, Suite: 203

Houston, TX 77005

Email: info@ovarcome.org

www.ovarcome.org, facebook.com/ovarcome, twitter.com/ovarcome

Please mail the application form along with the necessary verification documents for consideration. We will review the information and contact you with further details on disbursement.

All information is strictly confidential and is for Ovarcome official use ONLY.