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, 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. 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
- $100 Gas card
- $100 grocery card
- Optional counseling session via phone by a licensed clinical social worker

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

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<tr>
<th>No. of people in household</th>
<th>Gross Income</th>
<th>Income Verification</th>
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<tbody>
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<td>• The first two pages of signed copy of income tax return (SSN not required)</td>
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**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 review

**Please note:**

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

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**Ovarcome Non-Profit Inc.**

Mailing address:
2525 Robinhood Street, Suite: 212
Houston, TX 77005
Email: info@ovarcome.org, facebook.com/ovarcome, twitter.com/ovarcome
OvarCare APPLICATION FORM

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 ___________________________

PATIENT IDENTIFICATION:

Once the application is received and reviewed for accuracy and completion, we will contact you to schedule a phone call or an in-person office visit, depending on location. A recent picture is required at that time (drivers license picture not accepted) - we will advise as necessary in our communication.

The OvarCare Grant will be disbursed directly to you.
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: ( ) __________________________

Physician/Nurse/Social Worker Signature: _____________________________________________________________

Physician/Nurse/Social Worker Email (Required): ______________________________________________________
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: ______________________________________

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

TO: Ovarcome Non-Profit Inc.
2525 Robinhood Street, Suite 212, Houston, TX 77005

Our OvarCare program aspires to build a community of Survivors that inspire one another with stories of courage and inspiration. Our program is built on the principle that it is a support program for Survivors, by the Survivors. To that end, we periodically select a few stories of inspiration to share on our blogs or on our social media. The continuity of the OvarCare program also depends on availability of funds and donor contributions. We hope that you will share your story and help us support many more women who could benefit from the OvarCare program.

We would love you to be our OvarCare Ambassador! Please share your light, and help other women like you. Please submit the release permission below.

Release Permission:

I_____(please print full name), authorize Ovarcome to use my name, pictures, interviews, and likeness in all media, including but not limited to video, print, and electronic media, in such manner as the non-profit organization may deem advisable for the purpose of publicizing the work of Ovarcome in creating the OvarCare program and seeking funding from potential donors for program continuity. I understand that I am not entitled to reimbursement for the use of my name, photograph or participation in any and all media developed about and by Ovarcome Non-Profit Inc.

In signing this Consent, I understand and acknowledge that:

- I will not receive any remuneration for the use of my name, media coverage, or quote.
- I am over 18 years of age and otherwise legally competent to sign this Release.
- I have read this Release in its entirety and understood it prior to executing it.

Date:_________________________Signature:____________________________________

Address:______________________________________________

_____________________________________________________

Email Address:_________________________________________

Witness:______________________________________________
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.

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**IMPORTANT NOTES:**

- At this time, OvarCare is administered as a one-time grant only. Please send the application form along with the necessary verification documents for consideration. We will review the information and contact you with further details on completion and disbursement.

- Please review our website carefully for required documentation and send in applications completed in entirety. Incomplete applications will not be considered. We encourage your physician/nurse/social worker to send the applications to us.

- If you have additional questions on the application, please contact us at info@ovarcome.org. We appreciate the opportunity to serve you.

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