a 501(c) 3 non-profit organization providing financial assistance to uninsured breast cancer patients

Dear Potential MBA Recipient,

We are currently accepting applications for the Medical Bill Assistance Program only. Please review the following criteria. If you meet the guidelines below, please sign below and complete the attached form and send it back to the Mickaela foundation by mail or fax (303-452-1031). All information is needed for verification. All information will remain confidential. We will award funding as money becomes available on a first come, first serve basis.

Thank you,

Martine Reeh,
Executive Director,
The Mickaela Foundation

Treatment Policies and criteria:
We will not discriminate against natural or homeopathic treatments as long as there is documentation of studies and results. Our goal is to get patients healthy any way we can, and we are open to new research, medical advancements and treatment trials (if the patient is willing), in order to help find a cure.

We will never discriminate against any person, for any reason, provided they meet our criteria for treatment, which is never based on race, gender, religion or family status, etc.

Funding Criteria:
Age: 21 – 65
Gender: None
Services/Treatment Funded: Adjuvant only (Board to review complimentary therapies 12/02)
Employment: Must have some degree of verifiable employment at time of treatment or application. Self-employed or small business owner verified via bank statements, tax documents, state trade name or licensing, and P/L statements.
Insurance: None.
Income status:
- Individual: $8,000 - $30,000 per year
- Single w/ dependants: $8,000 - $36,000 per year
- Family w/ 3-5 dependants: $12,000 - $55,000
- Family w/ more than 5 dependants: $15,000 - $65,000

Residency: Current permanent Colorado residency. This will expand to other states as we grow.
References: 3 non-relative character references, including medical personnel, co-workers, employer, etc.

I have read and understand the criteria for funding.

Applicant signature: ____ Date: ___________

p.o. box 354 • henderson, co 80640 • 303.452.1898 • (f) 303.452.1031 • www.mickaela.com • www.mickaela.org

Medical Bill-Pay Assistance Program

Please complete the following form and either send it by mail to The Mickaela Foundation, P.O. Box 354, Henderson, CO 80640 or fax it to: 303-452-1031. Please read the criteria page included in this package, to make sure your situation complies with our guidelines.
All information will be kept confidential.

Name: ____

Address: ____

City:____

State:_______________________________ Zip: ______________________

Evening Phone:_______________________ Daytime Phone: _____________

SSN: _______________________________ DOB: ______________________

Insurance: ____ NONE ____ LIMITED ____ MEDICARE/MEDICAID ____ OTHER

Other: (explain) ____

Oncologist or Primary Physician: (referrer) ___________________________

Address: ____

City: ____

State:___________________________________ Zip:_________________

Phone:___________________________________

Diagnosis: _______________________________ Date: _______________

Treatment Protocols Prescribed: ____________________________________

____

____

Other Financial Assistance Received or Applied For: __________________

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____

Employment: ___ PART-TIME ___ FULL-TIME ___ SELF EMPLOYED ___ UNEMPLOYED

Employer: ____ Position: _______________

Address: ____ Mo. Gross Inc. $ ________

City: ____

State: ____ Zip: ___________________

Phone: ____ Supervisor: ____________

How Long Employed Here: _________________________

Previous Employer: (up to 3 years):

Employer: ____ Position: _______________

Address: ____ Mo. Gross Inc. $ ________

City: ____

State: ____ Zip: ___________________

Phone: ____ Supervisor: ____________

How Long Employed Here: _________________________

Employer: ____ Position: _______________

Address: ____ Mo. Gross Inc. $ ________

City: ____

State: ____ Zip: ___________________

Phone: ____ Supervisor: ____________

How Long Employed Here: _________________________

Outstanding Medical Debt:

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Facility/Doctor:__________________________________ Amount: $_____________

Bill Date: _______________________________________ Date Due:_____________

Contact Phone: __________________________________ Type: ________________

Patient Signature: _______________________________ Date: ________________

Referrer Signature: ______________________________ Date: ________________

Patient Authorization for Information Disclosure

I ____, hereby declare on this date,

___________________, that all relevant parties may discuss my medical records, treatments, billing and prognosis with representatives of the Mickaela Foundation.

Patient Name: (please print) ____

Patient Signature: ____

The Mickaela Foundation will only use the above permissions to verify and qualify an applicant's criteria for receipt of a treatment fund as well as adherence to State and Federal non-profit guidelines. Any and all information disclosed is kept strictly confidential and will not be shared with any other company or entities.

If you have questions about The Mickaela Foundation, you may contact us at 303-452-1898 or by email at info@mickaela.com