



Providing peace of mind... when you need it most.

## Sense of Security

1385 S. Colorado Blvd., Bldg A, Suite 302 • Denver, Colorado 80222  
303-669-3113 • 866-736-3113 • www.senseofsecurity.org

*We seek to provide a sense of security from financial hardship and enhance the quality of life for breast cancer patients in treatment.*

## What We Can Help With

Sense of Security provides monthly financial assistance to breast cancer patients if the applicant meets our criteria explained below under “Who We Can Help.” We don’t pay medical expenses, but we do help with regular, everyday expenses like, mortgage or rent, medical insurance premiums, groceries, child care, transportation and utilities.

All awards are made at the sole discretion of Sense of Security. Each application is given careful, individual consideration, but **Sense of Security does not guarantee assistance to anyone. Sense of Security does not pay for medical expenses.**

**Sense of Security has limited financial resources and will not be able to meet all your financial needs while you are undergoing treatment. We strongly encourage you to explore all other options for assistance during your treatment.**

## Who We Can Help

**Residency:** You must be living in the State of Colorado.

**Medical:** You must have been diagnosed with breast cancer **and** be within two months of breast cancer surgery (mastectomy, lumpectomy, axillary dissection, or sentinel node biopsy); **or** currently undergoing chemotherapy, radiation therapy, or gene therapy. *Please note that reconstruction or related complications and hormone therapies do not qualify you for assistance from Sense of Security.*

### **Financial**

1. *Income.* Your total household income from all sources (including wages, government assistance, and retirement funds if you are already retired) at the time of application must be less than the Area Median Income for the county in which you live (you don’t need to look that up -- we have that information). Additionally, your monthly expenses must exceed your monthly income.

2. *Assets.* Your cash or liquid assets (i.e., CDs, stocks, mutual funds) must be less than your expenses for the duration of treatment AND you may not own secondary real property or other liquid real or personal property. (Sense of Security does not require you to get rid of your primary residence, vehicle, or personal items to qualify for assistance from us. We may, however, disqualify you from receiving assistance or reduce the amount of assistance we offer, if you have liquid assets that could be used to pay your expenses.)

3. *Assistance in paying mortgage.* If you ask for help in paying your mortgage, the value of your home must be less than the median home sales price for the county you live in (we have the county information). In order for us to make this determination, you will need to provide a copy of the current year’s property tax assessment. If your mortgage does not qualify for assistance from us, we may still be able to provide you with assistance in other areas.

**Community and Government Resources:** Because Sense of Security does not have enough resources to meet all your financial needs, we very strongly suggest that you apply for all community and government resources that you could qualify for. We can guide you through this process; see Step 3 on “Application Directions and Checklist.”

### **IMPORTANT NOTICE:**

**Sense of Security may verify any information submitted. If you provide incorrect or misleading information on your application, on additional materials, or in any verbal communication with Sense of Security personnel, Sense of Security reserves the right to immediately suspend any and all current and future funding and recover all such amounts.**

## **Application Directions and Checklist** **Please Read Carefully**

**Please be sure to provide all the information requested here.  
An incomplete application will delay our ability to provide you with assistance.  
Please call us at (303)-669-3113 or (866) 736-3113 if you have questions or  
would like help completing the application.**

### **FOLLOW STEPS 1 - 6 TO COMPLETE THE SENSE OF SECURITY APPLICATION**

**Step 1: Read “What We Can Help With” and “Who We Can Help” on the front page.**

**Step 2: Read the “Application Directions” carefully and thoroughly (this page).**

**Step 3: Explore other financial resources.**

Because Sense of Security will be unable to provide all the financial help you may need, you will want to explore and apply for assistance from other financial resources that might be able to help you. We can help you determine what agencies or organizations, if any, might be able to help you. Complete either option A or B below, but not both:

A. Go to [www.senseofsecurity.org](http://www.senseofsecurity.org), click on the link for FAST™, the Financial Assistance Screening Tool, and follow directions. Print your "Financial Resources Profile," at the end, and follow directions for contacting agencies.

B. If you don't have internet access or would like help with this step, call Sense of Security at 303-669-3113 or toll-free at 866-736-3113. A staff member will guide you through Step 3A and mail the “Financial Resources Profile” with an application packet.

**Step 4: Fill out the Sense of Security Application completely and accurately (pages 1 - 4).**

**Step 5: Prepare the required attachments listed below in A and B.**

A. Proof that you live in Colorado - Submit a copy of your current Colorado Driver's License or I.D. with an address matching your application. If you do not have a Colorado-issued license or I.D., you can submit a rental contract or mortgage bill with your name on it; if these are in a spouse's, partner's or family member's name, please explain.

B. Medical status verification - Submit a signed letter from your oncologist on letterhead following the sample attached verifying your current diagnosis and treatment plan.

**Step 6: Read and check the boxes to verify the following information:**

- I understand Sense of Security does not pay for medical expenses of any kind.
- I live in the State of Colorado.
- I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy/cancer-related surgery and/or I am undergoing chemotherapy, radiation therapy, or gene therapy.
- I have signed the bottom of page 4 of the application which serves as a medical release, giving Sense of Security permission to obtain the necessary medical information to process my application.
- I understand that Sense of Security will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone interview.

**Mail your completed application and all required attachments to:  
Sense of Security, 1385 S. Colorado Blvd., Bldg A, Suite 302 • Denver, Colorado 80222**

## Personal Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Best number to reach you? Home Work Cell Best time to reach you? \_\_\_\_\_

Additional Contact Person that we may discuss your application with, if we can't reach you:

\_\_\_\_\_  
\_\_\_\_\_

Marital Status (circle): Single Married Other: \_\_\_\_\_

# of dependents: \_\_\_\_\_ # of Wage earners in home: \_\_\_\_\_ Total # in household: \_\_\_\_\_

Ethnicity (optional): African American Asian Pacific Caucasian Hispanic/Latino Native American Other: \_\_\_\_\_

Language(s) spoken: English Spanish Asian: \_\_\_\_\_ Other: \_\_\_\_\_

Educational level (circle): Grade School High School College Post-Graduate

Health insurance (please circle): None Medicaid Medicare CACP Private Other \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Monthly premium: \_\_\_\_\_

Insurance provided through: my employment spouse's employment other \_\_\_\_\_

How did you hear about Sense of Security? \_\_\_\_\_

Name of person who referred you: \_\_\_\_\_

Referring person's telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Employment status **before** your breast cancer diagnosis:

Full-time Part-Time On leave Self-employed Retired Unemployed

Employment status **after** your breast cancer diagnosis:

Full-time Part-Time On leave Self-employed Retired Unemployed

When did you last work? \_\_\_\_\_

## Financial Information - Income

### INCOME - ENTIRE HOUSEHOLD

What was your total monthly household income BEFORE your diagnosis and/or treatment: \$ \_\_\_\_\_

Please enter **current** income (in whole dollars) from all household sources in the blanks below.

|   | Monthly Income | One-time Gift or Assistance |
|---|----------------|-----------------------------|
| Your gross wages (before taxes or deductions)                   | _____          | _____                       |
| Spouse or partner's gross wages<br>(before taxes or deductions) | _____          | _____                       |
| Employer Disability Insurance                                   | _____          | _____                       |
| Unemployment Insurance  | _____          | _____                       |
| Retirement/Pension  | _____          | _____                       |
| 401K / IRA income   | _____          | _____                       |
| Social Security   | _____          | _____                       |
| SSI / SSDI  | _____          | _____                       |
| Old Age Pension (OAP)   | _____          | _____                       |
| Alimony/Child Support Received                                  | _____          | _____                       |
| Other Investment Income   | _____          | _____                       |
| Temporary Aid to Needy Families (TANF)                          | _____          | _____                       |
| Aid to the Needy and Disabled (AND)                             | _____          | _____                       |
| Low-Income Energy Assistance Program (LEAP)                     | _____          | _____                       |
| Food Stamps   | _____          | _____                       |
| Section 8 from HUD (housing supplement)                         | _____          | _____                       |
| Help from family members  | _____          | _____                       |
| Help from religious/faith community                             | _____          | _____                       |
| Help from friends   | _____          | _____                       |
| Help from other nonprofit organizations                         | _____          | _____                       |
| Other: _____  | _____          | _____                       |

**TOTAL CURRENT MONTHLY INCOME:** \$ \_\_\_\_\_

### ASSETS

|   | Principal Value | Monthly Income From |
|---|-----------------|---------------------|
| Cash/Checking                           | _____           | _____               |
| Savings                                 | _____           | _____               |
| Real Estate (not the house you live in) | _____           | _____               |
| Life Insurance                          | _____           | _____               |
| Investments                             | _____           | _____               |
| Retirement funds                        | _____           | _____               |
| Other: _____                            | _____           | _____               |

## Financial Information - Expenses

### EXPENSES - HOUSEHOLD

Please enter monthly expenses for your entire household in the blanks below.

|  | Monthly Expense | Occasional or One-time Expense (please specify) |
|--|-----------------|---|
| Fed/State/FICA/Medicare Employment Taxes | _____           | _____   |
| Other payroll deductions                 | _____           | _____   |
| Rent                                     | _____           | _____   |
| Mortgage                                 | _____           | _____   |
| Food                                     | _____           | _____   |
| Utilities _____                          | _____           | _____   |
| Utilities _____                          | _____           | _____   |
| Child care                               | _____           | _____   |
| Child support paid                       | _____           | _____   |
| TV/Internet/Cable/Satellite              | _____           | _____   |
| Telephone/cell including long distance   | _____           | _____   |
| Car payment                              | _____           | _____   |
| Gasoline                                 | _____           | _____   |
| Car insurance                            | _____           | _____   |
| Health insurance premium                 | _____           | _____   |
| Medical costs (after insurance)          | _____           | _____   |
| Medication costs (after insurance)       | _____           | _____   |
| Life insurance                           | _____           | _____   |
| Loan payments                            | _____           | _____   |
| Credit card payments                     | _____           | _____   |
| Household costs                          | _____           | _____   |
| Other: _____                             | _____           | _____   |
| Other: _____                             | _____           | _____   |
| Other: _____                             | _____           | _____   |
| Other: _____                             | _____           | _____   |

**TOTAL MONTHLY EXPENSES:**

\$

Have you sought creditor relief for any of the bills you itemized above? If so, describe in detail what you've requested, what has been approved, and what is pending.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Information

### Breast Cancer History

#### Current Diagnosis

Date Diagnosed: \_\_\_\_\_ Stage: \_\_\_\_\_ Type (if known): \_\_\_\_\_

#### **Surgery:**

- |   |             |
|---|-------------|
| <input type="checkbox"/> Lumpectomy           | Date: _____ |
| <input type="checkbox"/> Mastectomy           | Date: _____ |
| <input type="checkbox"/> Sentinel Node Biopsy | Date: _____ |
| <input type="checkbox"/> Axillary Dissection  | Date: _____ |

**Chemotherapy:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Radiation Therapy:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Gene Therapy:** Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**Other therapy or treatment details:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you being treated for a recurrence? Yes No

Please fill out the contact information below.

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgeon: \_\_\_\_\_

Oncologist: \_\_\_\_\_

Oncology Nurse: \_\_\_\_\_

Radiation Oncologist: \_\_\_\_\_

Social Worker/Case Manager: \_\_\_\_\_

Other: \_\_\_\_\_

I understand that Sense of Security (SOS) provides services that are free and that all awards are made at the sole discretion of Sense of Security. The information provided in this application is true. I release Sense of Security of all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize Sense of Security to release any information including my name, address, and type of assistance provided to any other social service agency at its discretion. I also authorize the release of any medical information and documentation required by Sense of Security for the purpose of verifying this application and I agree to sign any additional authorizations that may be required.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_