2025 STIPEND APPLICATION INSTRUCTIONS

Instructions: Please complete the attached Stipend Application. Applications may be submitted once per year.

To be eligible for a SASS stipend, the gross countable income of the economic unit (number of people living in the home), where the applicant lives, must be less than or equal to the SASS program income guidelines for economic unit size provided in the following chart, or must qualify under special conditions*. Proof of annual income must be included with the application to be approved.

Economic Unit	Annually	Monthly	Twice Monthly	Biweekly	Weekly
1	$28,953	$2,413	$1,207	$1,114	$557
2	$39,128	$3,261	$1,631	$1,505	$753
3	$49,303	$4,109	$2,055	$1,897	$949
4	$59,478	$4,957	$2,479	$2,288	$1,144
5	$69,653	$5,805	$2,903	$2,679	$1,340
6	$79,828	$6,653	$3,327	$3,071	$1,536
7	$90,003	$7,501	$3,751	$3,462	$1,731
8	$100,178	$8,349	$4,175	$3,853	$1,927

Applicants who are actively undergoing treatment for breast cancer during 2025 will be eligible for a stipend. The SASS stipend is a benefit to Licking County residents made possible through the support of funds donated by individuals and organizations to the Public Health Partnership of Licking County, a 501(C)(3) charitable organization (www.phplc.org). Diagnosis or recurrence must be specific to breast cancer to be considered for a stipend. The stipend amount is $500.00 per year up to $1,000 maximum per applicant within a 5-year period. Medical bills and/or records **do not** need to be submitted with applications. The total value and distribution of stipends is subject to change and based on availability of funds.

A SASS Medical Verification form, or a formal letter from your oncologist, must be included with each application. Formal verification letters from oncologists must be on hospital or clinic letterhead and include your physician's signature. All Medical Verification forms and/or letters must include the following**:**

- Patient's name
- Patient's date of birth
- Diagnosis
- Date of diagnosis/recurrence
- Current treatment or medical services provided

Once completed, please mail, or drop off the Stipend Application and SASS Medical Verification forms as well as the SASS Demographic Information form (if not already on file) to the address below. The Stipend Application form must be filled out in its entirety with an up-to-date SASS Medical Verification and SASS Demographic Information form on file to be considered complete. After the application has been reviewed and approved, please allow **4 weeks** for process of payment. Payment will be mailed to the address provided on the application. Please contact SASS at SASS@lickingcohealth.org or (740) 349-6535 with any questions. Checks must be cashed within 180 days, or the patient will need to reapply.

Tammy Jones, SASS for Breast Cancer Coordinator
c/o: Licking County Health Department
675 Price Road
Newark, Ohio 43055
Fax: (740) 349-6510

**Both parties recognize there may be extenuating circumstances to modify the terms of this application. In this event, a special conditions letter must be attached to this application. Approval will be subject to the evaluation of the situation. Special condition applicants will be notified via email of the stipend approval decision.*

SASS
Screening and Survivor Support
for Breast Cancer in Licking County

2025 STIPEND APPLICATION

Survivor Name: _____ Date of Birth: _____

Current address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Email: _____

Please check if the following statements are correct:

☐ I have been diagnosed with breast cancer during 2025 or am currently undergoing treatment for breast cancer.

☐ A SASS Medical Verification form or formal verification letter from my oncologist has been completed and is included with this application.

☐ I am submitting a completed SASS Demographic Information form or have submitted the form with a past medical reimbursement request.

☐ Meets income guidelines – less than or equal to 185% of the Federal Poverty Income Guidelines

*Please note: Specific expenses and/or medical records **DO NOT** need to be submitted with applications.

To the best of my knowledge, my statement on this Stipend Application is complete and true.

_____ _____

Signature Date

FOR OFFICE US ONLY:
Date received: _____ Status: _____

SASS
Screening and Survivor Support for Breast Cancer in Licking County

DEMOGRAPHIC INFORMATION

All personal information is confidential and for the sole use of the SASS program. Please fill out this form completely to help us better assist you.

*Please note: This Demographic Information form only needs to be filled out one time. Once a completed form is on file with SASS, you will **not** be required to resubmit this form for any future reimbursement requests.*

I. PERSONAL INFORMATION

Today's Date: _____/_____/_____ **Sex:** ☐ F ☐ M

First Name: _____ **Middle Initial:** ____ **Last Name:** _____

Date of Birth: _____/_____/_____ **Date of Diagnosis:** _____/_____/_____

Mailing Address: _____

City: _____ **Zip Code:** _____

Phone Number: (_____) _____-_____

Email: _____

Race (please check all that apply):

☐ Caucasian
☐ African American
☐ American Indian and Alaska Native
☐ Asian
☐ Native Hawaiian and Other Pacific Islander
☐ Hispanic or Latino Origin

Current Marital Status:

☐ Single ☐ Separated ☐ Divorced
☐ Married ☐ Widowed

Current medical insurance status: ☐ Insured ☐ Uninsured

If insured, what type of insurance?

☐ Medicare
☐ Medicaid
☐ Private (Company Name: _____)
☐ Other: _____

II. HEALTH HISTORY

How did you first discover concerns about your breast that led to your cancer diagnosis?
(Circle all that apply)

☐ Self-Exam ☐ Routine Clinical Breast Exam ☐ Routine Mammogram

☐ Other: _____

Have you had a recurrence of breast cancer? ☐ YES ☐ NO

If YES, what year was your recurrence(s)? _____

Was it local or a new area? _____

III. RISK FACTORS

1. How old were you when you first began menstruating? _____
2. At the time of diagnosis, were you still having regular menstrual periods?

   ☐ YES ☐ NO, they were irregular ☐ NO, I was post-menopausal

   If no, what was your age when you stopped having menstrual periods? _____

   Was this NATURAL or MEDICAL? _____
3. Have you had any children? ☐ YES ☐ NO

   If yes, please list your age at the birth of each child: _____

   Did you breastfeed any of your children? ☐ YES ☐ NO

   If yes, how long did you breastfeed each child? _____
   _____
   _____
4. Do you smoke cigarettes? ☐ YES ☐ NO If yes, what age did you start smoking? _____

   On average, how many cigarettes do you smoke per day? _____
5. Do you drink alcohol? ☐ YES ☐ NO If yes, how many drinks do you have per week? _____
6. Do you have a family history of breast cancer? ☐ YES ☐ NO
7. Do you have a family history of ovarian cancer? ☐ YES ☐ NO

IV. FINANCIAL ELIGIBILITY

1. How many people are in your family unit? _____
   a. *A family is defined as 1 or more persons living in one dwelling place who are related by blood, marriage, law or have a joint child. To be considered a separate family unit, the individual must show he/she can provide for the majority of his/her living expenses.*

2. What is your gross family income per year? _____

3. Are you able to provide proof of annual income? ☐ YES ☐ NO
   a. *Please include proof of annual income when submitting stipend application*

V. MEDICAL CARE

Please list the treating physician, practice name, and office location of the following medical providers:

Primary Care Physician: _____

Practice Name: _____ City: _____

Oncologist: _____

Practice Name: _____ City: _____

Surgical Care: _____

Practice Name: _____ City: _____

Other: _____

Practice Name: _____ City: _____

I certify that the information I have provided above is complete and true to the best of my knowledge.

_____ _____

Signature **Date**

Thank you for taking the time to fill out this form completely. Please send all documents to:

SASS for Breast Cancer
c/o: Licking County Health Department
675 Price Road
Newark, OH 43055

2025 MEDICAL VERIFICATION
MUST BE COMPLETED BY THE TREATING PHYSICIAN

Physician Information

First Name: _____ Last name: _____

Specialty: _____ Name of Practice: _____

Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

Email: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

Date of Diagnosis: _____

Is the patient currently undergoing treatment? ____ YES ____ NO

Current treatments and/or medications during 2025 for breast cancer treatment:

_____

_____

I certify the patient described above is under my care and the information included on this Medical Verification form is complete and true.

_____ _____

Signature Date

Please contact the SASS program at SASS@lickingcohealth.org or (740) 349-6535 with any questions.