BTW | Treatment Assistance Application

Please fill out the application and email a copy to: btwcancers@gmail.com. You will be contacted within 10 business days of application submission.

Personal Information

First Name

Last Name

Email

Phone

DOB

Street Address

City

State

Zip Code

Treatment Information

Physician/Financial Counselor Phone

Physician/Financial Counselor Email Address

Name of Treating Physician for Cancer Care

Name of Treatment Location

Treatment Location Street Address

City

State

Zip Code

Which type of gynecological cancer are you (the patient) being treated for? Please select all that apply.

- [ ] Cervical Cancer
- [ ] Ovarian Cancer
- [ ] Vulvar Cancer
- [ ] Endometrial (Uterine) Cancer
- [ ] Vaginal Cancer

Financial Details

Does the patient have medical insurance coverage? If yes, we will contact you via email to provide a copy of insurance.

- ( ) Yes
- ( ) No

Financial Details Continued

Type of financial assistance requested:

- [ ] Medical Bills
- [ ] Medical Transportation
- [ ] Gas
- [ ] Groceries

Total Amount of Assistance Requested (USD)

Total Gross Annual Income

What does total gross income include?

Gross salary, unemployment payments, Disability and Worker's Compensation, Social Security and/or Supplemental benefits, Public Assistance, Other income

Please explain any circumstances that we should consider for your application.