

****Please Note - we are currently only accepting applications for NWI and Chicagoland residents and there is a limit of \$800.00 per year. This amount is available to you for 12 months from the time of your initial disbursement and cannot exceed the annual limit. You will be contacted with a decision within 10 business days of application submission. Coverage for groceries and gas will be given in the form of a gift card. Coverage for medical bills/transportation services will be paid directly to the servicer provider.**

Personal Information

First Name

Last Name

Email

Phone

DOB

Street Address

City

State

Zip Code

Treatment Information

In order to process your request, Below The Waist, Inc. may contact your physician to verify your treatment or medical condition related to this application. By submitting this application, you authorize Below The Waist, Inc. to reach out to your healthcare provider(s) for the purpose of confirming your treatment details. Your privacy and the confidentiality of your medical information are of the utmost importance. All communications with your physician will be handled securely.

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

Date (MM/DD/YYYY)

I confirm in active treatment. Date of last treatment (surgery, radiation, chemotherapy):

