Instructions for Completing the StringsforaCURE® Gift Card Application

StringsforaCURE® is an Erie, PA based 501(c)(3) non-profit charitable organization, founded by Elisa Guida, a two-time breast cancer survivor, as her way of giving back to the breast cancer community. We are dedicated to providing education, comfort, support and financial assistance directly to cancer patients, primarily those with breast cancer.

The StringsforaCURE Foundation is an independent non-profit, charitable organization and is not associated with American Cancer Society, CancerCare, or any other organizations, health systems, hospitals or cancer centers. The funding for the StringsforaCURE programs is provided by the generous donations of our supporters, mostly in Erie and the Northwestern Pennsylvania Region.

Our gift card program provides $100 gas, grocery and pharmacy gift cards to breast cancer patients to help ease the burden during the patient’s breast cancer journey. Breast cancer patients are eligible to receive a total of two gift cards within an eighteen (18) month period.

Qualifications for a StringsforaCURE Gift Card:
Gift cards are currently available for breast cancer patients who are U.S. citizens and permanent residents of the USA providing the patient meets the qualification requirements below.

To qualify for your first StringsforaCURE Gift Card for gas, grocery or pharmacy, you must meet the following requirements:

1. New breast cancer diagnosis or a diagnosis of a recurrence within the last year.

   **AND**

2. Currently in active treatment for the new breast cancer diagnosis or recurrence
   a. Active treatment is defined as the period after a positive breast cancer diagnosis has been determined (i.e. diagnostic biopsy) and during which therapies are being administrated, including:
      i. Surgical procedures (i.e. single or bi-lateral mastectomy, lumpectomy, axillary dissection, or sentinel node biopsy) followed by Chemotherapy, Radiation, and/or Clinical Trials
      ii. Chemotherapy
      iii. Radiation
      iv. Clinical Trials

For the purposes of a Gift Card application, long-term hormonal therapies (i.e. Tamoxifen, Fareston, Arimidex, Aromasin, Femara, Zoladex / Lupron, Megace, and Halotestin) are NOT considered ACTIVE treatment.

If you are applying for a second gift card and you are finished with your treatments, then you will need to provide a letter from your oncologist or breast cancer surgeon, who is doing your 6 month follow ups. As a second time gift card applicant:

1. You already received a gas, grocery or pharmacy gift card from StringsforaCURE within the last 6-12 months.

   **AND**

2. You are participating in 6 month follow-ups with either your oncologist or breast cancer surgeon.
Completing the StringsforaCURE Gift Card Application:

NOTE: All sections must be completed and all requested information must be provided. Incomplete applications will not be processed!

SECTION I - PATIENT INFORMATION
Please enter the date that you are completing the application and complete all demographic and contact information, including name, birthdate, address, phone numbers and e-mail address. Please print clearly!! It may be necessary for StringsforaCURE to contact you regarding your application.

SECTION II - HEALTHCARE PROFESSIONAL INFORMATION
Under “Contact Information for Physician Treating Cancer,” please print the physician’s name, hospital or clinic, address, and phone and fax numbers for the physician treating your cancer, such as an oncologist, radiologist or surgeon. (This is not your primary care physician’s information.)

Under “Diagnosis Information,” include the type of cancer and stage. Indicate whether this is a new diagnosis or a recurrence and the date(s) of those diagnoses. Please indicate the type of Active Treatment you are currently undergoing.

Under “Healthcare Provider Information,” print the name, phone number, and email address of the health care provider who is verifying your diagnosis and indicate whether the health care provider is a physician, nurse, social worker, or physical therapist. The application must be signed by this Healthcare Provider. Even if the patient’s physician signs the application, a separate letter from the physician is still required.

SECTION III - GIFT CARD REQUEST
Select the preferred retailer for the retailer for the gift card that you are requesting. Please be sure that the retailer is available in your area.

SECTION IV – REQUIRED DOCUMENTATION
Indicate whether you have previously received a gift card and if so, indicate the approximate date.

In order to confirm your diagnosis, first-time applicants must submit the following documentation with your application:
- Signed letter from physician treating the cancer indicating the diagnosis and that you are in active treatment.
- Treatment plan/schedule from the facility where you are being treated that includes your name and the plan or schedule for your active treatment(s).

If this is your second gift card request and you are no longer receiving treatment, then you must provide the following:
- Signed letter from the medical oncologist or your breast cancer surgeon indicating your diagnosis and that you are under his/her follow-up care.

SECTION IV – PATIENT VERIFICATION OF INFORMATION
By signing the application, you, the patient, are verifying that all of the information is truthful and accurate. Any information that has been knowingly falsified could be considered an act of fraud and will be addressed accordingly. Additionally, you are authorizing StringsforaCURE to verify any healthcare information provided with your healthcare providers, permitting StringsforaCURE to contact you to verify receipt of the gift card and to inquire with the retailer as to how the gift card was spent.

Questions about this application can be directed to Elisa Guida.
   Email: elisa@StringsforaCURE.org
Mail completed application and required documentation to:

StringsforaCURE
P.O. Box 9823
Erie, PA 16505

ATTN: GC APP

All applications must be mailed. Applications received electronically will not be processed.

We recommend that you make a copy of your completed application for your records before mailing the application in the event that any questions arise.

PLEASE NOTE:

- Processing of your gift card application may take up to 8 to 10 weeks or longer.
- Do not contact StringsforaCURE to check on the status of your application because we are busy processing all of the applications we receive!
- Gift Card applications are processed in the order in which they are received.

Before mailing, please use the checklist below to ensure that your application is complete. This will help to ensure that your application will be processed as quickly as possible! If your application is incomplete or missing information, your application will not be processed.

<table>
<thead>
<tr>
<th>HAVE YOU COMPLETED THE ENTIRE APPLICATION?</th>
</tr>
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<tbody>
<tr>
<td>☐ Patient Information – Ensure that contact information complete and legible.</td>
</tr>
<tr>
<td>☐ Physician Treating Cancer – Ensure that the Contact Information for your physician is complete.</td>
</tr>
<tr>
<td>☐ Diagnosis Information – Diagnosis, Diagnosis/Recurrence Date, and Type of Active Treatment must be complete.</td>
</tr>
<tr>
<td>☐ Healthcare Provider Information Verifying Diagnosis – Contact Information for your healthcare provider must be complete.</td>
</tr>
<tr>
<td>☐ Healthcare provider verifying the diagnosis must sign/date the application.</td>
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<tr>
<td>☐ Did you check the Desired Gift Card? Only one retailer (Walmart, Giant Eagle, Sheetz, etc.) should be selected.</td>
</tr>
<tr>
<td>☐ Have you signed and dated the Application?</td>
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<table>
<thead>
<tr>
<th>HAVE YOU SUBMITTED THE REQUIRED DOCUMENTATION?</th>
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<tbody>
<tr>
<td>☐ Required documentation for 1st Time applicants:</td>
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<tr>
<td>☐ Letter signed by physician treating the cancer indicating your diagnosis and that you are under active treatment. Required – even if the physician signs the application.</td>
</tr>
<tr>
<td>☐ Treatment plan/schedule from the facility where you are being treated that includes your name and the plan or schedule for your qualified treatment(s).</td>
</tr>
<tr>
<td>☐ Required documentation for 2nd Time applicants:</td>
</tr>
<tr>
<td>☐ Letter signed by medical oncologist or breast cancer surgeon treating the cancer indicating the diagnosis and that you are under his/her follow-up care. Required – even if the physician signs the application.</td>
</tr>
<tr>
<td>☐ Ensure that the Physician Letter is addressed to the correct organization/foundation. Letters to organizations / foundations other than StringsforaCURE will not be accepted.</td>
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</tbody>
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StringsforaCURE® is an Erie, PA based 501(c)(3) non-profit charitable organization, founded by Elisa Guida, a two-time breast cancer survivor, as her way of “Giving Back” to the breast cancer community. We are dedicated to providing education, comfort, support and financial assistance to cancer patients, primarily those with breast cancer.

StringsforaCURE® Gift Card Application
The StringsforaCURE Gift Card Program is intended to provide $100 Gas, Grocery and Pharmacy gift cards to breast cancer patients who are in active treatment.

<table>
<thead>
<tr>
<th>SECTION I - PATIENT INFORMATION</th>
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<tbody>
<tr>
<td>Application Date __________________</td>
</tr>
<tr>
<td>Last Name _______________________ First Name___________________ Date of Birth__________</td>
</tr>
<tr>
<td>Street Address ____________________________ ____________________________</td>
</tr>
<tr>
<td>City, State, Zip ____________________________ ____________________________</td>
</tr>
<tr>
<td>Home Phone (<strong><strong>)____________________ Cell Phone (</strong></strong>)____________________</td>
</tr>
<tr>
<td>May we leave a message? □ Yes □ No May we leave a message? □ Yes □ No</td>
</tr>
<tr>
<td>E-mail Address ____________________________________________________________</td>
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<table>
<thead>
<tr>
<th>SECTION II - HEALTHCARE PROFESSIONAL INFORMATION</th>
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<tbody>
<tr>
<td>*******<strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong>Contact Information for Physician Treating Cancer</strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td>Name of Physician Treating Cancer__________________</td>
</tr>
<tr>
<td>Hospital/Clinic ____________________________________________</td>
</tr>
<tr>
<td>Address ____________________________________________________________</td>
</tr>
<tr>
<td>Phone (<strong><strong>)____________________ Fax (</strong></strong>)____________________</td>
</tr>
<tr>
<td>********<strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong><strong>Diagnosis Information</strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></strong></td>
</tr>
<tr>
<td>Primary Cancer ____________________________________________ Stage ______________________</td>
</tr>
<tr>
<td>□ New Diagnosis Date Diagnosed____________ □ Recurrence Date Diagnosed _____________</td>
</tr>
<tr>
<td>Type of Active Treatment: __________________________________________________________________</td>
</tr>
<tr>
<td>********************************** Healthcare Provider Information**************************</td>
</tr>
<tr>
<td>Printed Name ______________________________________ Phone (____) ______________________</td>
</tr>
<tr>
<td>E-mail Address ____________________________________________</td>
</tr>
<tr>
<td>Relationship to patient: □ Physician □ Nurse □ Social Worker □ Other: __________________</td>
</tr>
<tr>
<td>Signature ____________________________________________ Date________________________</td>
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</table>

NOTE: Application must be signed by the Healthcare provider verifying the diagnosis information. If this section is signed by the physician, this does not replace the need for a letter from the physician.
SECTION III - GIFT CARD REQUEST

Preferred Retailer (Please check only ONE)
Please be sure the selected retailer is available in your area.

☐ Citgo(Country Fair)  ☐ Giant Eagle  ☐ Walmart  ☐ CVS
☐ Kwik-Fill  ☐ Wegmans  ☐ Target  ☐ Rite-Aid
☐ Sheetz  ☐ Tops

SECTION IV - REQUIRED DOCUMENTATION

Documentation Type
Have you previously received a gift card from StringsforaCURE? Yes ☐ No ☐
If Yes, when (approximate)? ______________________________
If you answered “No” to the question above, you are a first-time Gift Card Applicant and you must submit BOTH of these documents
☐ Letter signed by physician treating the cancer indicating your diagnosis and that you are under active treatment.
☐ Treatment plan/schedule from the facility where you are being treated that includes your name and the plan or schedule for your qualified treatment(s).

If you answered Yes to the question above, then this is a second gift card application and you will need to provide a letter from your oncologist or breast cancer surgeon, who is doing your 6 month follow ups.
☐ Letter signed by medical oncologist or breast cancer surgeon treating the cancer indicating the diagnosis and that you are under his/her follow-up care.

SECTION V – PATIENT VERIFICATION OF INFORMATION

As the patient, I understand that by signing this application I agree with the following (please check each box acknowledging the statement):
☐ Verify that the information provided above is truthful and accurate to the best of my knowledge.
☐ Authorize StringsforaCURE to verify any healthcare information provided with my healthcare providers.
☐ Permit StringsforaCURE to contact me to verify receipt of the gift card.
☐ Authorize StringsforaCURE to contact the retailer to verify how the gift card was spent.

Signature __________________________________________________ Date_______________________

All sections must be completed. All required documentation must be attached.
Incomplete applications and applications that are illegible will NOT be processed.

HOW DID YOU HEAR ABOUT US?

Please tell us how you heard about StringsforaCURE?
________________________________________________________________________________________

- Please allow 8-10 weeks for the delivery of the gift card.
- Please do not contact StringsforaCURE to check on the status of your application because we are busy processing all of the applications we receive!
- Gift Card applications are processed in the order in which they are received.
Mail completed application and required documentation to:
StringsforaCURE
P.O. Box 9823
Erie, PA 16505

ATTN: GC APP

All applications must be mailed. Applications received electronically will not be processed.
Incomplete applications or applications without the required documentation will not be processed.

Before mailing, please make sure that the following has been done:
- [ ] All sections of the application have been completed.
- [ ] The required healthcare information has been completed.
- [ ] The desired Gift Card retailer has been selected.
- [ ] A letter from the Physician treating the patient has been included.
- [ ] For first-time Gift Card applicants, the treatment plan has been included.
- [ ] Healthcare provider has signed the application in Section II.
- [ ] Patient has signed the application in Section V.

The StringsforaCURE Foundation adheres to the following policies when processing Gift Card applications:
- All applications, and the information contained therein, shall be strictly confidential.
- StringsforaCURE® Board reserves the right to verify all information provided to ensure all resources are distributed without discrimination as to age, race, sex or creed and shall comply with all State and Federal laws related thereto.
- An application may be put on hold, pending the availability of funds.
- Any information that has been knowingly falsified could be considered an act of fraud and will be addressed accordingly.