MyHopeChest™
BREAST RECONSTRUCTION for Uninsured Survivors

Client Agreement

Breast Reconstruction Program

Dear Breast Cancer Survivor:

We understand that you wish to be considered as a candidate to receive charitable benefits through the My Hope Chest (MHC) breast reconstruction program. This letter, when signed by you, confirms your agreement with the terms of participation in this program.

CANDIDATE CRITERIA

To be considered as a candidate for the MHC breast reconstruction program, you must meet all of the following criteria:

1. Have a current* and complete application on file with MHC. ***Must be updated every 12 months from date of initial application.***
2. Have a current* letter of Medicaid *denial* for breast reconstructive surgery on file with MHC. ***Must be updated every 12 months from date of initial denial letter.***
3. Have copies of your tax returns for the most recent two tax years (joint return if married) on file with MHC.
4. Have three months *current* bank statements on file with MHC.
5. Demonstrate household income at or below 200% of the federal poverty guidelines, which currently are:

Family Size	Gross Yearly Income (at or below the amounts listed)
1.	$22,340
2.	$30,260
3.	$38,180
4.	$46,100
5.	$54,020
6.	$61,940

6. Have two letters of recommendation on file with MHC supporting your financial need for assistance. These recommendations will be from your doctor(s), family member(s), friend or employer confirming that you desire the breast reconstruction surgery and need financial assistance to have it.
7. Have a "consultation" from a plastic surgeon (to be considered for out of state surgery).
8. Confirm here by placing your initials that you have tried *every* avenue available to you to raise the funds to pay for your reconstruction first before seeking benefits from MHC, such as family, friends, savings or credit cards.** _____ (Initial)

Be mindful, that as a grassroots organization our mission is to help individuals first that have absolutely no means to help them fund their breast reconstruction.

Please honor and respect our commitment on this important issue.

PROGRAM PROVIDER PROTOCOLS

Our breast reconstruction program operates through the participation of three health care providers, a plastic surgeon, an anesthesiologist and the medical facility where they have privileges. To secure health care providers to work with MHC's program, ***we have agreed to the following terms for candidate and client conduct***:

1. A candidate must meet the MHC social and financial program criteria.
2. The staff of MHC facilitates all initial scheduling and correspondence with the participating plastic surgeon's office unless otherwise designated. Candidates are not to call the surgeon's office directly until directed to do so by MHC or the participating plastic surgeon *after* My Hope Chest has accepted the candidate as a client. *Failure to comply may result in being removed from further participation in the MHC program.*
3. Proper dress and appropriate behavior must be maintained during appointments. Behavior deemed difficult, demanding or inappropriate by the plastic surgeon or his/her staff may be grounds for removal from further participation in the MHC program.

YOUR SUPPORT SYSTEM

My Hope Chest is deeply concerned with the total well-being of our clients who receive surgery. Depending on the type of surgery your plastic surgeon recommends, a breast reconstruction may require a commitment of **up to a year**. If selected to receive benefits from MHC breast reconstruction program, you may be required to have weekly visits to your plastic surgeon. To secure plastic surgeons to work with MHC, our candidates must be screened to assure they have a stable environment for recuperation *after* surgery. While My Hope Chest acts as a payment gateway for fees for medical services, we are not currently set up to provide other patient support services.

YES	**NO**	
□	□	Do you have an individual who can do all you heavy lifting (of children, groceries etc.) immediately after surgery?
□	□	Do you have reliable transportation for weekly doctor visits, if necessary?
□	□	Do you have the financial means to cover your basic living expenses—food, clothing and shelter—during recuperation?
□	□	Do you have the finances to pay for the prescription medications for after surgery (i.e. pain medicine, etc.)?
□	□	Do you smoke?**

****As smoking before or after surgery can seriously affect and even cause breast reconstruction to fail, applicants must abstain from smoking prior to surgery and during their reconstruction recovery period. Plastic surgeons require patients to be nicotine tested the months leading up to and after surgery. If you are unable to abstain from smoking or nicotine, do not apply to My Hope Chest for assistance.**

TERMS OF AGREEMENT
YOU MUST INITIAL ALL POINTS or Agreement will be void and your Application will be denied.

By signing below, you agree that if you are selected to receive benefits as a client of the MHC breast reconstruction program, you*:*

1. Agree to be a volunteer "Angel" and to commit at least 60 hours to MHC within a period of 1 year, before and/or following your surgery. This helps raise awareness for MHC and breast reconstruction for uninsured survivors. ____ ***(Initial)***
2. Agree and understand that any surgery paid for by MHC is **voluntary** and under a separate contract **with the plastic surgeon**, not MHC. You understand that MHC merely acts as a provider of payment for of my medical services. Therefore, you agree that that you will not hold MHC or any of its employees, agents Directors or volunteers responsible or legally liable for any and all claims, losses, damages, expenses, costs

or fees resulting from your participation in the MHC breast reconstruction program, surgery, anesthesiology, hospitalization, recuperation, or any other related activities and events. ____ (***Initial)***

3. Agree to execute the necessary waivers under the Health Insurance Portability and Accountability Act ("HIPAA") to allow your plastic surgeon to release to MHC information pertaining to your medical condition, your appointments, your surgery dates and the surgeon's opinions, recommendations and prognosis. **You must include MHC on your HIPPA agreement with the surgeon. _____** (***Initial)***

4. **Agree and understand that should any complications arise due to your failure to follow doctor's orders that then result in additional medical services or surgeries outside what is considered reasonable and customary for your procedure (including the removal of the tissue expander or implants), any and all compensation for medical services and fees for ALL medical services provided will become YOUR responsibility and under such circumstances, My Hope Chest will be released from any obligation to fund or pay for ANY of your medical fees and costs. _____** ***(Initial)***

By signing below, you further agree that you have been truthful in responding to everything on this Agreement and on the Application submitted with it and that copies of all documents submitted to MHC are true copies of genuine documents that do not contain false statements. You acknowledge that is YOUR responsibility to follow up periodically about your application status, keep your information current each year and notify MHC of any change in phone number, email or mailing address. Failure to do so may result in having your application put on "inactive" list and you may have to begin the application process over in order to remain under consideration for MHC benefits.

_____ _____
SIGNATURE DATE

_____
PRINT NAME

PLEASE MAIL THIS AGREEMENT ALONG WITH THE APPLICATION
AND ALL SUPPORTING DOCUMENTS TO:

PO BOX 3081 Seminole, FL 33775

PHONE (727) 642-4243
info@myhopechest.org