Debra K. Dupree-Westberry College Scholarship

Scholarship applications are accepted for the Spring and Fall semesters. Scholarships are awarded to those already accepted to, or currently attending college/university. Please do not apply while you are still in the college application process. For your application to be considered for review, please see below:

Eligibility Questionnaire and applications are accepted in the timeframes identified below:

- May 1st through June 30th for the Fall semester
- October 1st through November 30th for the Spring semester

Please be advised that the application and review process can take up to 90days.

Program Guidelines

- A student who has a parent currently diagnosed with breast cancer or has lost a parent due to breast cancer.
- Open to all regardless of age, race, gender, ethnicity, or medical insurance coverage.

Chosen Butterflies prides itself on providing support to breast cancer patients, survivors, and their families. ***Fraudulent applications and materials will not be accepted and may be subject to administrative, civil, or criminal liability.*** Be aware, that by submitting this form, you are agreeing to the following statement:

"I do hereby attest that this information it true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me administrative, civil, or criminal liability."

Complete the below form so Chosen Butterflies may determine your eligibility for this program.

****Please note, this is not an application for the program, this is a questionnaire to determine if you qualify for this program. ****

Chosen Butterflies will review your eligibility and be in touch with you via email regarding the next steps. Please be sure to check you Junk or Spam folders.

Fields marked with a * are required.

First Name*_____ Last Name*_____

Phone*_____ Email*_____

Have you lost a parent due to breast cancer? If no, you do not qualify for this program. * _____ YES _____ NO

Do you have documents stating the diagnosis/loss? This is required. * _____ YES _____ NO

Are you able to provide supporting documents (i.e. medical records, income verification, bills, etc.) as attachments with your application? This is required. * _____ YES _____ NO

Can you make the required $25.00 Pay-It-Forward -Contribution via PayPal? This contribution will assist others in need of Chosen Butterflies' services. This is required. You do NOT need to make the contribution at the time. * _____ YES _____ NO

How did you hear about Chosen Butterflies? * _____

Eligibility Questionnaire

Chosen Butterflies Inc
1771 Goblet Cove St
Kissimmee, FL 34746
Phone: (352) 272-3272 Email: chosenbutterflies@chosenbutterflies.com

Chosen Butterflies prides itself on providing support to breast cancer patients, survivors, and their families. ***Fraudulent applications and materials will not be accepted and may be subject to administrative, civil, or criminal liability.*** Be aware, that by submitting this form, you are agreeing to the following statement:

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Chosen Butterflies will review your eligibility and be in touch with you via email regarding the next steps. Please be sure to check you Junk or Spam folders.

Fields marked with an * are required.

First Name*_____ Last Name*_____

Phone*_____ Email*_____

Have you been diagnosed with breast cancer? If no, you do not qualify for this program. *
_____ YES _____ NO

What was the date of your initial breast cancer diagnosis? * _____

Are you in remission or active treatment? * _____

If you are in remission or have been declared "no evidence of disease" please provide that date. _____

Do you have medical documents stating these dates (diagnosis/remission date)? * ____YES ____NO

Are you able to provide supporting documents (i.e. medical records, income verification, bills, etc.) as attachments with your application? * ____ YES ____ NO

Can you make the required $25.00 Pay-It-Forward-Contribution via PayPal? This contribution will assist others in need of Chosen Butterflies' services. This is required. You do NOT need to make a contribution at this time. * _____ YES _____ NO

Can you complete and attach the HIPPA Compliant Authorization (filled out by you) and Medical Information (filled out by a medical professional). * _____ YES _____ NO

Medical Information Form

DO NOT MAIL OR FAX THIS FORM

Faxed or mailed forms will not be considered.

This form is meant to be submitted as an attachment to an application that is completed. Please return the completed form to the patient.

This form must be filled out by an authorized provider, such as a physician, nurse, social worker, or patient/nurse navigator. The form must be filled out in entirety for consideration for eligibility.

Form completed by (check one):
__Physician __Nurse __Social Worker __Patient Navigator __Nurse Navigator

Patient Name: _____ Provider: _____
Current Diagnosis: _____
Date Diagnosed: _____ Stage/Grade: _____

Cancer Type:
__In Situ __Invasive Ductal Carcinoma __Inflammatory __Recurrent Metastasis ___ Other

Complete all that are applicable:

Lumpectomy Date: _____ Mastectomy Date: _____
Chemotherapy Start Date: _____ Projected/Actual End Date: _____
Radiation Start Date: _____ Projected/Actual End Date: _____
Remission/No Evidence of Disease Date: _____
Check One:
__Active Treatment or ___Maintenance Medication (i.e. tamoxifen, anastrozole, arimidex…)

Provider Signature: _____ Date: _____
Title: _____ Email: _____
Printed Name: _____ Phone: _____
If applicable: Licensing State_____ License Number_____

Additional contact person on care team
Name: _____ Phone: _____
Email: _____
If applicable: Licensing State_____ License Number_____

1771 Goblet Cove St
Kissimmee, FL 34746
Phone: (352) 272-3272 Email: chosenbutterflies@chosenbutterflies.com

HIPAA Compliant Authorization to Use and Disclose Protected Health Information

Pursuant to 45 C.F.R. § 164.508

DO NOT MAIL OR FAX THIS FORM

This form is meant to be submitted as an attachment to an application that is completed.

Faxed or mailed forms will not be considered.

TO: _____
Name of Healthcare Provider/Physician/Facility ("Provider")

_____
Address

_____
City, State and Zip Code

RE: Chosen Butterflies' grant program eligibility of (PLEASE WRITE CLEARLY):

_____ _____
Patient's Full Name Period of Care

_____ _____
Patient's Address Patient's Date of Birth

_____ _____
Patient's City, State Zip Code Telephone Number

_____
Patient's Email Address

1. I hereby authorize the Provider listed above to disclose protected health information ("PHI"), as described below in the "Medical Information Form", to Chosen Butterflies, INC for the period of care listed above. Any facsimile or photocopy of the authorization shall authorize the release of the PHI requested.

2. This disclosure is limited to information pertaining to diagnosis and treatment of breast cancer, specifically as requested on the attached form (Medical Information Form) from Chosen Butterflies, INC. The PHI is disclosed for the purpose of determining eligibility for programs administered by UBCF.

3. This authorization shall remain in effect until six (6) months after the effective date of the patient's signature.

4. The recipient of the health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information.

5. I understand that I have the right to revoke this authorization, in writing, at any time except to the extent that the provider listed above has acted in reliance upon it, by sending written notification to the provider.

6. I understand that PHI used or disclosed pursuant to this authorization may be redisclosed by the recipient and its confidentiality may no longer be protected by federal or state law.

7. My refusal to sign this authorization will not affect my ability to receive treatment. FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for copies of information, or your copies may be mailed along with an invoice.

_____ _____

Signature of Individual Print Name

_____ _____

Signature of Personal Representative Print Name

_____

Date

If this authorization is signed by someone other than the patient, please state the representative's relationship to the patient: _____