THE Blue FUND
SUPPORT FOR MEN

MIU MEN'S HEALTH FOUNDATION

***ABOUT THE BLUE FUND***

The Blue Fund is a program offered by MIU Men's Health Foundation, providing limited short-term financial assistance to newly diagnosed Prostate Cancer patients during initial treatment easing financial stress, so men can focus on healing.

Financial assistance is available for qualified men undergoing initial treatment for prostate cancer, providing up to $1,000 per month for up to three months, based on available funds and need. Men must be able to demonstrate need, based upon federal poverty guidelines.

To be considered, application and bills must be submitted by the 17th of the month and bill must be able to be paid in full. Among the types of debts that will be considered are utility bills, mortgage or rent payments, car or car insurance payments, license plate renewal, and phone cards to ensure regular communication with physicians. The Blue Fund cannot pay for medical bills, credit cards, or delinquent accounts.

***GUIDELINES***

- Financial assistance available for qualified men undergoing initial treatment of prostate cancer. (Does not include disease recurrence, active surveillance, or ongoing hormone therapy.)
- Amount of assistance given on short term basis (up to 3 months) with a financial cap of $1,000 per month per patient based on application acceptance, available program funds and need.
- A shorter reapplication form can be used in subsequent months if full application received within last two months. Copies of current bills required with application, along with any changes to original application.
- Includes possible direct bill payment of utility bills, mortgage or rent, car or car insurance payment, license plate tabs, phone cards to keep in contact with doctors are some types that may be considered.
- Bill must be able to be paid in full to be considered. No partial payments will be made. Bills in the process of collection will not be considered.
- The Blue Fund is not an emergency fund and cannot provide immediate assistance.
- Funding will be based on discretionary guidelines as determined by MIU Men's Health Foundation and fund availability.
- The Blue Fund does not discriminate on the basis of race, religion, age, national origin, marital status, disability, or sexual orientation.
- No funds can be paid to Michigan Institute of Urology, P.C.
- No one associated with the Foundation is eligible for the benefit.

***HOW TO APPLY:***

You can apply online by visiting https://www.miumenshealthfoundation.org/the-blue-fund/, or fill out the application that follows and return via USPS to:

MIU Men's Health Foundation
419 Golf View Lane
Rochester, MI 48309

Be sure to enclose all required forms:

---

- ☐ Completed application
- ☐ Signed letter from your urologist/oncologist or nurse/social worker verifying current diagnosis and detailing treatment plan. (Medical Information form)
- ☐ Completed financial disclosure form
- ☐ Signed Release Form
- ☐ Completed HIPAA form to verify medical status
- ☐ If employed and on leave, a letter from employer specifying leave status
- ☐ Copy of driver's license with current address
- ☐ The federal tax returns for past 2 years, for you and spouse/partner
- ☐ A copy of checking and savings account statements for past 2 months, for you and spouse/partner
- ☐ Copies of all bills you wish considered for payment.

---

## APPLICATION FOR FINANCIAL ASSISTANCE

Name_____ DOB_____

Address _____

City_____ State_____ Zip _____

Email _____

Phone (home): _____ (cell): _____ Permission to leave a message: Yes / No

I allow you to communicate about my Blue Fund application with _____(name)

_____(relationship)

Date diagnosed with Prostate Cancer: _____

Date/Type of treatment: _____

Insurance Coverage: None Medicare Medicaid VA Private: _____

Employment Status: Full-time Part-time Sick Leave Unemployed Retired
Disabled: Permanent / Temporary Total / Partial

Employer:_____

From which other agencies have you asked for help, if any? _____

Please list all household members residing with you.

| Name | Relationship | Age | Dependent? |
|---|---|---|---|
| | | | ☐ yes ☐ no |
| | | | ☐ yes ☐ no |
| | | | ☐ yes ☐ no |
| | | | ☐ yes ☐ no |

How did you hear about The Blue Fund? _____

### APPLICANT RELEASE AND ACKNOWLEDGMENT

- ☐ I attest that I am a prostate cancer survivor, undergoing active treatment.
- ☐ I attest all information provided is accurate and complete to the best of my knowledge.
- ☐ I will allow The Blue Fund to do a follow-up survey.

Signature _____ Date _____

**MEDICAL INFORMATION**

***(To be filled out by urologist, oncologist, licensed social worker, or nurse navigator)***

Name_____ DOB_____

Date diagnosed with Prostate Cancer _____

Stage / Grade _____

Procedure type and date(s)_____

Treatment type and date(s) _____

Urologist _____ Office phone _____

Oncologist _____ Office phone _____

Social Worker _____ Facility _____ Phone_____

Nurse Navigator _____ Facility _____ Phone_____

***Form completed by:***

Signature: _____

Name: _____

Title: _____

Phone: _____

Office address: _____

_____

***Please return to:***
***MIU Men's Health Foundation, 419 Golf View Lane, Rochester, MI 48309***
***or***
***info@MIUMensHealthFoundation.org***

**FINANCIAL DISCLOSURE**

Name_____ Date Of Birth_____

| ASSETS | SELF | HOUSEHOLD MEMBER(S) |
|---|---|---|
| 401(K), IRA, STOCKS-BONDS, ETC. | | |
| SAVINGS/CHECKING ACCOUNT TOTALS | | |
| | | |

| INCOME | SELF | HOUSEHOLD MEMBER(S) | Change after diagnosis? |
|---|---|---|---|
| SALARY | | | |
| SOCIAL SECURITY | | | |
| MEDICAID SUPPLEMENTS | | | |
| MEDICARE SUPPLEMENTS | | | |
| DISABILITY INCOME | | | |
| VETERAN'S BENEFITS | | | |
| RENTAL INCOME | | | |
| OTHER INCOME (specify) | | | |
| | | | |
| | | | |
| | | | |
| TOTAL MONTHLY INCOME | | | |

| EXPENSES | MONTHLY AMOUNT | DUE DATE |
|---|---|---|
| MORTGAGE/RENT | | |
| HOMEOWNERS INSURANCE | | |
| AUTO LOAN/LEASE | | |
| | | |

| EXPENSES | MONTHLY AMOUNT | DUE DATE |
|---|---|---|
| AUTO INSURANCE | | |
| HEALTH INSURANCE PREMIUM | | |
| GAS/ELECTRIC | | |
| TELEPHONE | | |
| WATER | | |
| MEDICATION COPAYS | | |
| OTHER EXPENSES (specify) | | |
| | | |
| | | |
| | | |

| **RECENT HARDSHIP?** (explain) |
|---|
| |
| |

| BILL(S) SUBMITTED FOR CONSIDERATION FOR PAYMENT | AMOUNT | DUE DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**APPLICANT RELEASE AND ACKNOWLEDGMENT**

- ☐ I attest all information provided is accurate and complete to the best of my knowledge.
- ☐ I will allow The Blue Fund to further assess my financial need and agree to provide accurate information to the best of my knowledge.

**Signature** _____ **Date** _____

# RELEASE FORM

CHECK BOXES IN TOP BOX

*This upper box allows us to share your Blue Fund experience to help others. We will never use your name without consent.*

☐ I, _____, give and forever grant to MIU Men's Health Foundation, a not-for-profit corporation, and its successors, assigns, or licensees (the "Foundation") the right to use, publish and copyright throughout the world in perpetuity any photograph of me, in whole or part (the "Work"), including alterations, modifications, derivations and composites of the Work, in advertising and promotion of the Foundation. This right shall include the right to combine the Work, in whole or in part, with other images, and to alter the Work, by digital means or otherwise, so long as the use is for a lawful purpose.

☐ I agree that I shall have no right, title or interest in or to the Work, or any material included in or as part of the Work, or in combination with the Work, and that I shall have no claim of any kind or nature against the Foundation, its officers, directors, agents, attorneys, or employees based on its exercise of any rights I have granted in this Release. In addition, I waive any and all rights I may have to inspect or approve of the Work, whether or not it is used in any final product. Finally, all rights that I grant to the Foundation are irrevocable and not subject to rescission, restraint or injunction under any circumstances.

☐ I consent to the publication of any personal information to explain my personal involvement with prostate cancer and the assistance that I have received from the Foundation in conjunction with the Work or separate from the Work.

☐ I further agree to defend, indemnify, and hold the Foundation harmless from any claims of any kind brought against the Foundation or any of its officers, directors, employees, or agents as a result of any information provided to the Foundation by the undersigned which information the Foundation publishes.

OR LOWER BOX

*This lower box does not allow us to share your experience with others. We will never use your name without consent.*

☐ I, _____, **do not give** MIU Men's Health Foundation, a not-for-profit corporation, and its successors, assigns, or licensees (the "Foundation") the right to use, publish and copyright throughout the world in perpetuity any photograph of me.

☐ I, _____, **do not give** MIU Men's Health Foundation, a not-for-profit corporation, and its successors, assigns, or licensees (the "Foundation") the right to use, publish and copyright throughout the world in perpetuity my personal information explaining the assistance I have received.

☐ I further agree to defend, indemnify, and hold the Foundation harmless from any claims of any kind brought against the Foundation or any of its officers, directors, employees, or agents as a result of any information provided to the Foundation by the undersigned which information the Foundation publishes.

☐ I certify that I am at least eighteen years of age and otherwise meet the age of majority requirements in the State of Michigan, where I am a resident.

Signature: _____

Print Name: _____

Address: _____

City/State/Zip _____

Telephone: _____ Date: _____

# HIPAA RELEASE OF PATIENT INFORMATION

TO: _____

*Name of Healthcare Provider/Physician/Facility*

_____

*Street Address*

_____

*City, State and Zip Code*

RE: Patient Name: _____

Date of Birth: _____ Social Security Number (Last 4 Digits): _____

I authorize and request the disclosure of all protected health information related to any prostate cancer diagnosis and treatment to MIU Men's Health Foundation ("Foundation") needed for its use and disclosure relative to my participation in its program ("The Blue Fund") and/or Foundation's marketing activities to promote Foundation's charitable purposes. I expressly request that the designated record custodian of all covered entities identified above disclose full and complete protected medical information, **as needed during qualification process**, including the following.

- All medical records
- All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.
- All laboratory, pathology and radiology records and films
- All pharmacy/prescription records

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following Purposes: **For eligibility determinations regarding my request for grants and other offered Foundation services [and to assist Foundation in the promotion of its charitable purposes.]**

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to **MIU Men's Health Foundation**, whose address is: **419 Golf View Lane, Rochester, MI 48309.** Foundation agrees to pay reasonable charges incurred by you to supply copies of such records.

## HIPAA RELEASE OF PATIENT INFORMATION, continued

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until the undersigned delivers to you a signed and dated written revocation of this Authorization.

_____ _____

*Signature of Patient or Legally Authorized Representative* *Date*

_____ _____

*Name of Legally Authorized Representative to Patient* *Relationship to Patient*

**FAQ**

***What does The Blue Fund do?***

The Blue Fund provides limited short-term financial assistance to newly diagnosed Prostate Cancer patients during initial treatment.

***How much can The Blue Fund provide to me?***

The Blue Fund provides assistance short term (up to three months) with a maximum of $1000 per month.

***Do I need to reapply each month?***

Yes. A shortened form may be used if an application was received within last two months. This form can be found on our website.

***Will I receive the money directly?***

No. The Blue Fund provides payment to the creditors directly.

***What bills can The Blue Fund cover?***

The Blue Fund can pay for utility bills, mortgage or rent, car or car insurance payment, license plate tabs, health insurance premiums, or prescription co-pays; no partial payments of bills will be made and assistance can't exceed $1000 per month.

***What bills are not covered?***

The Blue Fund cannot pay for medical bills, credit cards, or delinquent accounts.

***How can I qualify for this assistance?***

The Blue Fund uses 2023 Federal Poverty Guidelines as a guide. Each case will be considered on an individual basis, taking into consideration recent hardships incurred and debt to income ratios.

Applicants must also be newly diagnosed with prostate cancer and undergoing their initial treatment (examples- surgery, radiation). Applicants experiencing a recurrence or receiving only hormone therapy are not eligible.

***How can I submit my application for assistance?***

Applications and accompanying paperwork can be mailed to:

MIU Men's Health Foundation
419 Golf View Lane
Rochester, MI 48309

---

**Applications can also be filled out online and accompanying documentation uploaded:**
**https://www.miumenshealthfoundation.org/the-blue-fund/**

***Do you have an email for other communication?***
Yes!  You may reach us via email at info@MIUMensHealthFoundation.org

***Where does The Blue Fund money come from?***
MIU Men's Health Foundation receives private donations and raises funds at our signature events for The Blue Fund.

***Are my donations tax-deductible?***
Yes! Any funds donated to MIU Men's Health Foundation are tax deductible under section 501(c)(3). Funds can be designated to The Blue Fund or any other program offered. Visit our website and click on our donation page.

***ELIGIBILITY***

| 2023 Federal Poverty Guidelines | | |
|---|---|---|
| # In Household | 2023 Levels | 250% of Level |
| 1 | $13,590 | $33,975 |
| 2 | $18,310 | $45,775 |
| 3 | $23,030 | $57,575 |
| 4 | $27,750 | $69,375 |
| 5 | $32,470 | $81,175 |
| 6 | $37,190 | $92,975 |
| 7 | $41,910 | $104,775 |
| 8 | $46,630 | $116,575 |

THE Blue FUND
SUPPORT FOR MEN

MIU MEN'S HEALTH FOUNDATION

FIGHT like a MAN
DETROIT