



Santa Fe Community Foundation

WE MAKE IT EASY TO CARE FOR SANTA FE

**Santa Fe Community Foundation
Daniel and Elizabeth Ronel Fund for Breast Reconstruction**

Description

The Daniel and Elizabeth Ronel Fund for Breast Reconstruction was established in 2007 to provide breast reconstruction surgery for women who otherwise could not afford it.

The Fund can distribute funds to pharmacies, hospitals, and providers, but not to individuals. The Fund does not cover primary treatment of breast cancer including chemotherapy, radiation, and mastectomy. The Fund also does not provide for expenses that are covered by Medicaid.

The Fund is advised by Santa Fe Community Foundation which evaluates applications for financial assistance and determines if medical bills can be paid (partially or in full) from the Fund. Plastic surgeons participating in this program agree to waive their usual fees.

The goods and services that can be covered by this Fund include costs associated with:

- insurance deductibles
- pharmaceutical products
- anesthesiology fees
- operating room fees; including implants
- home medical equipment and supplies
- other goods and services determined to be essential to the surgery and recovery.

Requests for financial assistance must meet the following criteria:

- The applicant must have undergone a mastectomy for breast cancer
- The applicant must lack health insurance coverage and the ability to personally pay for breast reconstruction
- Applicants must be residents of Northern New Mexico

Documentation Required:

- A letter from a health care provider indicating patient has undergone a mastectomy due to breast cancer
- A written statement indicating the lack of health insurance or insurance coverage for breast reconstruction
- Household income (income tax return or other proof of income)
- Proof of residency in Northern New Mexico

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APPLICATION FOR FUNDS

Applicant Name _____

Address _____

Phone number(s) _____

Email: _____

Total Household Income: \$ _____

Primary Health Care Provider or Oncologist Name: _____

Primary Health Care Provider or Oncologist Phone: _____

- 1. Include all required materials for consideration listed in application procedure.**
- 2. Describe the circumstances that lead to the financial need (attach a separate sheet, if necessary):**

I pledge that the information provided above (and attached) is accurate. Providing misleading or incorrect information will be reason for disqualification.

Signature: _____

Date: _____

Submit application to:
Erika Davila, Program Associate
Santa Fe Community Foundation
P.O. Box 1827
Santa Fe, NM 87504-1827
(505) 988-9715 ext. 6
FAX (505) 988-1829
edavila@santafecf.org
www.santafecf.org