



Applicant's Name: _____

APPLICATION CHECKLIST AND FORMS

The following items must be included in your application package. If they are not, processing will be delayed until after receipt. Please check off each item enclosed. All items are required. Include this sheet in your package.

X	Document or Description
	Completed Pink Fund Application included in this file. Be sure to check off the boxes on page 6.
	Completed Financial Disclosure Form included in this file.
	Completed HIPPA Form included in this file
	A signed letter from your oncologist (on letterhead) verifying your current diagnosis and treatment plan, or a letter (on letterhead) from a licensed social worker, case worker, patient advocate or nurse navigator. You must supply The Pink Fund with an email address for the social worker, case worker, patient advocate or nurse navigator.
	A signed letter from your current employer indicating your employment status. You must be actively employed, or have lost your job within the last 24 months.
	A copy of your driver's license or valid State i.d. card with an address matching that on your application form and the bills submitted for consideration.
	The front page of your tax returns from the last two years, and those of your spouse or partner, if filed separately, in order to verify household income.
	A copy of your most recent checking and savings account statements.
	<p>Copies of ALL bills you wish considered for payment. Do NOT send originals. The bills must show: your name (or spouse's or partner's name), the account number, the current balance due, and the complete address to which payments are sent. Bills considered are:</p> <ul style="list-style-type: none"> • Car Insurance Premiums • Car Loans • Mortgage/Rent* • Health Insurance Premiums • Utility Bills • Phone Bills <p>*IF YOU RENT your residence, you must send a complete copy of your lease/rental agreement, including the name and address of the person or agency to whom payments are made.</p> <p>** NOTE: payments will not be made to the applicant or to any family member. The Pink Fund will not make partial mortgage payments or payments on delinquent mortgages.</p>

We must have a current email address at which to contact you and/or your social worker. If you do not have an email address, our communications with you will be through the U.S. Mail or by phone and may be significantly slower.

MAIL YOUR COMPLETED APPLICATION and all required documents to:

The Pink Fund
 PO Box 603
 Bloomfield Hills, MI 48303



Applicant's Name: _____

APPLICATION FOR FINANCIAL ASSISTANCE

Please read this page completely and carefully before you complete the application pages.

The Pink Fund provides direct bill payment on behalf of breast cancer patients in active treatment, or within 90 days of active treatment, who have lost all or part of their income as a result of the cancer diagnosis or treatment protocol.

Active treatment is considered a single or bi-lateral mastectomy, lumpectomy, axillary dissection or sentinel node biopsy, chemotherapy or radiation. Please note that complications from surgery, (i.e., blood clots, staph infections, lymphadema, etc.), biological or target therapies, and reconstruction are not considered part of active treatment for purposes of qualifying for assistance from The Pink Fund.

Recovery is defined as a period of time determined by your physician, but not exceeding 90 days after the completion of active treatment.

The Pink Fund provides direct payment of bills such as: car payments, mortgage or home rent payments, payments for medical or auto insurance, and utility payments. The Pink Fund **does not** make payments for any medical treatments, prescription drugs, hormone therapy, medical co-pays, insurance deductibles, prostheses, wigs, or other medically-related charges.

The Pink Fund will make direct payments to the recipient's creditors. No funds are directed to the recipient themselves, and we are not able to make payments on accounts which you have set as auto deduct from your bank account. The Pink Fund will not make payments to family members. All assistance is subject to available funding. The Pink Fund will not make partial mortgage payments and will not make payments on delinquent mortgages.

Maximum time aid can be received by any one individual is three months. The Pink Fund reserves the right to decline any applicant for incomplete information, inconsistent or questionable information, lack of funds or other reasons determined by the Pink Fund.

You do NOT qualify if you are currently receiving monthly financial aid through:

1. The State and/or Social Security Disability programs,
2. Financial aid, etc. through a local Department of Human Services of Welfare Unit, or through the TANF (temporary assistance for needy families) Act



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2. You do NOT qualify if you are retired and receiving a monthly pension check from your former employer and do not require a second job to pay for basic monthly living expenses, which The Pink Fund defines as: rent/mortgage, utilities, car payment/insurance, and health insurance

3. You do NOT qualify if you are on Medicaid, unless it is through the Breast and Cervical Cancer Treatment Program in your state. If you are enrolled in the Breast & Cervical Cancer program in your state, you must provide verification.

4. You do NOT qualify if your utility bills are currently being paid through a local Low income Home Energy Assistance Program, such as (NEAR) National Energy Assistance Referral, (866) 674-6327

5. You do NOT qualify if you have been unemployed for more than 24 months.

6. You do NOT qualify if you are working in an unrecognized revenue producing position which is defined as:

1. Currently not paying federal or state taxes
2. Receiving cash "under the table" which is not reported to the government.



Applicant's Name: _____

SECTION 1: Personal and Financial Information

First Name: _____ Last Name: _____

Date of Birth: _____ Social Security#: _____

Street Address: _____

City, State, Zip code _____

E-Mail address: _____ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Best time to reach you? _____ Circle best number to reach you.

Name, **email address**, and phone number of Social Worker, Case Manager, Patient Advocate, Nurse Navigator or Physician with whom we may discuss your application if we can't reach you or need further information (also see HIPPA release form):

Employment Status **before** your breast cancer diagnosis: (circle one)

full-time part-time on disability sick leave self-employed retired unemployed

Please indicate the Name and address of your Employer, including a primary contact person and their phone number or email address.

Employment Status **after** your breast cancer diagnosis: (circle one)

full-time part-time on disability sick leave self-employed retired unemployed

Month/Date/Year you last worked: _____

Marital Status, (circle one) Single Married Divorced

Number of Wage Earners in Household: _____



Applicant's Name: _____

Number and Ages of Dependents in Household: _____

Total number of People Living in Household: _____

Disability Insurance (Not SSD), (circle one): Yes No
If Yes, state waiting period, and how much is paid per week or month and for how many months _____

Type of Health Insurance, (circle one):
None Medicare Medicaid* Private Supplied by employer Supplied by spouse's employer
Private Other Insurance Company: _____

*Medicaid recipients must be enrolled in the Breast & Cervical Cancer Treatment program in their state and provide verification.

Medical Information / Breast Cancer History

Current Diagnosis

Date Diagnosed: _____ Stage/Grade: _____

Type (if known, please circle one):
In-Situ, Invasive Ductal Carcinoma, Inflammatory, Pagets Disease of the Nipple, Recurrent/Metastasis

Surgery Date: _____

Lumpectomy Date: _____

Mastectomy Date: _____

Sentinel Node Biopsy Date: _____

Axillary's Dissection Date: _____

Chemotherapy: _____ Start Date: _____ End Date: _____

Radiation: _____ Start Date: _____ End Date: _____

Other therapy or treatment details: _____

Are you being treated for a recurrence, (circle one): Yes No



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Please fill provide name, location, and phone for the following:

Surgeon: _____

Oncologist/Oncology Nurse: _____

Social Worker/Case Manager: _____

Social Worker/Case Manager email (required) _____

Other:

Our funders require follow-up surveys of patient outcomes at 3, 6, and 12 months after assistance. Should the Pink Fund assist you, you will be contacted with survey questions. Your participation will help us better serve all future applicants.

I understand that all awards are made at the sole discretion of The Pink Fund. The information provided in this application is true. I release The Pink Fund of all liabilities or claims whatsoever arising out of the direct bill payment program. I authorize The Pink Fund to release any information including my name, address and type of assistance provided to any other social service agency at its discretion as it relates to my case and the verification of this application.

I agree to assign any additional authorizations that may be required.

Applicant's Signature: _____

Date: _____

Print Name: _____

Applicant Name: _____

Please indicate what type of assistance you need immediately:

<u>Direct Bill Pay Type</u>	<u>Payable to:</u>	<u>for Month of</u>	<u>Amount</u>
Mortgage/Rent:	_____	_____	_____
Utility Bill(s): (please provide names of service providers)	_____	_____	_____
Car payment:	_____	_____	_____



Applicant's Name: _____

Car Insurance: _____

Health Insurance: _____

Other: _____

Other: _____

SECTION 2: Personal/Financial Information

Ethnicity: *(this info is required for State and National Grant Approvals)*: _____

Please indicate what Language(s) you speak: _____

Highest Educational Level, (circle one): Grade School High School Some College Grad Degree Post-Grad

How did you hear about The Pink Fund? _____

Name, e-mail address and telephone number of person who referred you? _____

Please check the following boxes

- I understand The Pink Fund does not pay for medical expenses of any kind.
- I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy/cancer-related surgery, and/or I am currently undergoing chemotherapy or radiation or completed active treatment within the 90 days.
- By checking this box, I am giving my full authorization and permission to The Pink Fund to obtain the necessary medical information to process my application.
- I understand The Pink Fund may ask personal questions about my treatment and financial status if needed. I agree to provide accurate answers in a telephone interview.

Applicant's Signature: _____ Date: _____

You must also complete the Financial Disclosure Form: (2 pages) and The HIPPA Authorization Form and provide all documents requested. Incomplete applications will not be considered.

Please mail your application and/or any additional confidential financial information you may be sharing with us by next day air through the US Post Office, United Parcel Service or Federal Express. This will protect both you and The Pink Fund.

The address is: **The Pink Fund, P.O. Box 603, Bloomfield Hills, MI 48303**



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The Pink Fund Financial Disclosure Form

*****IMPORTANT: Please provide copy of front page IRS Form 1040 from last two years, and last two months statements from all checking/savings accounts**

ASSETS	TOTAL
1) 401Ks or Retirement Savings Account	
2) Money in Bank and/or Credit Unions (<i>include Checking, Savings, and any Money Market Accounts</i>)	
3) Savings Bonds (<i>current market value</i>)	
4) Stocks, Bonds & Mutual Funds (<i>current market value</i>)	
5) Traditional and/or Roth IRA's	
6) Owned Real Estate (<i>current market value</i>)	
7) Automobile(s) – (<i>Kelly Blue Book or Edmunds.com market value</i>)	
8) Life Insurance Cash Value or Equity	
9) Other Personal Properties or Assets (<i>provide separate list if over \$5,000</i>)	
9A) TOTAL ASSETS: (add up all items listed in rows 1-9)	
LIABILITIES	
10) Notes payable to the Bank:	-----
a) Current Balance on Mortgage Loan	
b) Current Balance on Auto Loan(s)	



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c) Current Balance on Home Equity Loan			
d) Current Balance on any other Personal credit lines/loans			
11) Taxes Due:	-----		
a) Property Taxes for primary property only (<i>indicate if Summer or Winter and date when due</i>)			
b) Federal Taxes past due			
c) State Taxes past due			
d) Other Taxes (please explain)			
12) Total of other outstanding Debts, (credit cards etc.):			
12A) TOTAL LIABILITIES: (add up all Items listed in Liabilities Section)			
PRESENT NET WORTH: (Subtract Total Assets from Total Liabilities, (9A-12A))			
SOURCES OF MONTHLY INCOME	SELF:	PARTNER:	TOTAL:
a) Monthly Salary(ies)			
b) Social Security Disability and/or State Disability			
c) Workers Compensation			
d) Veteran's Benefit			
e) Pension and/or annuity payment			
f) Armed Services Allotment			



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g) Alimony/Child Support			
h) Interest and Dividends from Assets			
i) Gross rent from property(ies)			
j) Unemployment Benefits from State (MESC)			
k) Disability Policy benefits or Sick Pay from Employer (<i>indicate % of gross and for how many weeks</i>)			
l) Friends/Family:			
L1) TOTAL MONTHLY INCOME (add up Rows a – l):			
MONTHLY EXPENSES	SELF:	PARTNER:	TOTAL:
m) Mortgage/Rent			
n) Insurance (house/apartment) (<i>do not list separately if included in mortgage payment above</i>)			
o) Automobile Loan(s)			
p) Car(s) Insurance			
q) Utilities (<i>indicate if on NEAR or Low income home energy assistance program</i>)			
r) Life Insurance			
s) Property Taxes (<i>do not list separately if included in mortgage payment above</i>)			
t) Groceries/Drugstore (<i>please indicate if on food stamps, and do not include prescription drugs</i>)			
u) Cell phone/Telephone (<i>do NOT include expenses for cable</i>)			



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v) Child Support Payments to ex-spouse			
V1) TOTAL MONTHLY EXPENSES (add up rows m – v):			
CASH available (Subtract Row V1 from Row L1):			

Patient Signature: _____ Date: _____

Comments:
