PINK AID'S PINK PURSE | CONNECTICUT
APPLICATION FOR COMPASSIONATE ASSISTANCE

Pink Aid's Pink Purse Fund provides compassionate assistance to individuals in need due to their Breast Cancer diagnosis. Please note we can only consider and fund non-medical requests. Some examples of areas to apply for are screening/testing, food, rent, utilities, childcare, transportation, counseling, lymphedema sleeves, wigs and prosthetics.

All applications must be filled out completely and legibly in order for our Pink Purse Committee to process. Applications received by 5pm each Monday will be considered within 7 days. Applications received after the weekly deadline will be considered the following week.

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children under the age of 18 living in your home: _____

Other Dependents in your home that contribute to monthly expenses: _____

This section to be completed by CURRENT NURSE NAVIGATOR/SOCIAL WORKER on behalf of the patient.

Nurse Navigator/Social Worker Name: _____

Email Address: _____ Phone Number: _____

Referring Institution: _____

Patient's Breast Cancer Doctor's Name: _____

If different from above, please list address, phone number and referring institution:

_____

_____

_____

Has patient applied for Pink Purse funding in the past? ☐ Yes ☐ No If yes, when? _____

What is the patient applying for (in order of priority)?

1. _____ Amount: _____

2. _____ Amount: _____

3. _____ Amount: _____

Pink Aid prefers to pay bills that are in patient's name.
If bill is not in patient's name, please explain the relationship to bill holder: _____

Is the payee name, address and account number on the bill? ☐ Yes ☐ No

If no, please provide Payee's Name, Address and Account #:

_____

_____

Are any other organizations paying this bill? ☐ Yes ☐ No

If yes, please provide the name of the organization(s), amount and date: _____

_____

_____

Beyond applicant's financial needs, are there any special circumstances that our Pink Purse Committee should take into consideration when reviewing the application?

_____

_____

Please note that all bills will be verified prior to payment and that Pink Purse does not pay directly to individuals. Pink Aid pays up to $1,000 per twelve month period on behalf of qualified patients.

PINK PURSE REQUIRES the following documentation to be submitted with application:

- A signed letter from doctor on his/her letterhead confirming breast cancer diagnosis including date of latest treatment and/or screening requests.
- A signed letter from a Nurse Navigator, Hospital Social Worker or 501C3 Administrator verifying that applicant has been screened and qualifies for financial assistance.
- A current copy of bill to be paid dated within 30 days of application.
- If requesting rent payment, please be sure to include a current lease or current legal binding document from the landlord or a current mortgage statement

Completed application and appropriate documentation should be submitted via email to **pinkpurseCT@pinkaid.org** or by mail to: **Pink Aid, Inc. Pink Purse, P.O. Box 5157, Westport, CT 06881**

Please email **pinkpurseCT@pinkaid.org** or call our office at 844.PINKAID with any questions.

By signing this application, you are certifying that the information and statements contained (including any other material and information submitted) are true and correct. and that you give Pink Aid permission to contact a payee should we have additional questions.

Date: _____

Printed Name: _____

Signature: _____