PINK AID'S PINK PURSE | LONG ISLAND
APPLICATION FOR COMPASSIONATE ASSISTANCE

Pink Aid's Pink Purse Fund provides compassionate assistance to individuals in need due to their Breast Cancer diagnosis and currently undergoing treatment. 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, car payments, 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 of the 25th of the month in order to be considered for review and payment by the 10th of the following month. Applications received after the monthly deadline will be considered with the applications received on the 25th of the following month.

Date: ______________________

APPLICANT INFORMATION ***To be completed by the current nurse navigator or social worker on behalf of applicant.***

Applicant's Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: ______________________

Date of Birth: ______________________ Email Address: ______________________

Reason for Application. Please give a brief explanation of the circumstances that bring you to Pink Purse:

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NURSE NAVIGATOR/SOCIAL WORKER INFORMATION ***To be completed by the current nurse navigator or social worker on behalf of applicant.***

Nurse Navigator/Social Worker Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: ______________________

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:

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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 #:

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Are any other organizations paying this bill? ☐ Yes ☐ No
If yes, please provide the name of the organization(s), amount and date: ____________

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Is applicant currently receiving financial assistance from any other organization or agency? ☐ Yes ☐ No

If yes, please list: ______________________________

INSTRUCTIONS FOR SUBMISSION:

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 $750 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. Please include name, phone number and address of the Company to be paid and account number. If requesting rent payment please be sure to include a lease or a legal binding document from your landlord. Please note that all bills will be verified prior to payment and that the Pink Purse does not pay directly to Individuals.
- 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 Pink Purse LI Committee at **pinkpurseLI@pinkaid.org** or by mail to: **Pink Aid, Inc. Pink Purse, P.O. Box 5157, Westport, CT 06881**

Please email **pinkpurseLI@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.

Printed Name: ______________________________ Date: ____________

Signature: ______________________________