Pink Aid's Pink Purse provides emergency assistance to underserved breast cancer patients in financial crisis who are undergoing active treatment for a breast cancer diagnosis. Funds provide emergency assistance for non-medical, household expenses with a 48 hour turn-around time once an application and all documentation has been received.

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.

**Active treatment is defined as the period after a positive breast cancer diagnosis has been made and during which therapies are being administered, including surgical procedures, to remove the cancer (e.g. single or bilater mastectomy, lumpectomy), chemotherapy or radiation. Active treatment does not include long-term hormonal therapies such as Tamoxifen or an Aromatase Inhibitor.*

TODAY'S DATE: ____________________

SECTION A: PATIENT INFORMATION

Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Phone Number: ____________________ Email: ____________________

Primary Language Spoken: ____________________

Applicant Date of Birth: ____________________

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

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

Other household members in your home that contribute to monthly expenses: ____________________

Are you currently employed: Yes: ☐ No: ☐

If yes, Occupation: ____________________

Are you receiving Social Security Disability: Yes: ☐ No: ☐

Is your household income 500% or less of the federal poverty level based on last year's federal tax return? Yes: ☐ No: ☐

IF YES, PLEASE CONTINUE.

Is Aromatase Therapy or Hormonal Therapy your only current therapy? Yes: ☐ No: ☐

IF THE ANSWER TO THE ABOVE QUESTION IS YES, YOU ARE INELIGIBLE FOR PINK PURSE ASSISTANCE. IF YOUR ANSWER IS NO, PLEASE CONTINUE.

Pink Aid's Pink Purse

SECTION B: CURRENT TREATMENT

Date of Diagnosis: ______________________________

Hospital/Treatment Center: ______________________________

Check all that apply regarding active treatment:

☐ I had or will be having surgery for my breast cancer diagnosis. Please provide date:

____

☐ I am receiving chemotherapy treatments. Date of last treatment:

____

☐ I am receiving Radiation therapy. Date of last treatment:

____

IF YOU CHECKED AT LEAST ONE OF THE BOXES ABOVE, PLEASE COMPLETE SECTION C.

SECTION C: TO BE COMPLETED BY SOCIAL WORKER/NURSE NAVIGATOR OR PATIENT

Breast Cancer Physician: ______________________________

Nurse Navigator or Social Worker:: ______________________________

Email Address: ____________________ Phone Number: ____________________

Has the patient applied for Pink Purse in the Past? : Yes: ☐ No: ☐

If Yes, When? : ______________________________

Please list, in order of priority, all bills and month requested for funding.
*Note: All bills must be current and within 60 days of the month requesting funds for
and in the patient's name (or spouse) and patient's place of residency.
Bills should include the account number, the current balance due and
the complete address to which payments are sent.

1. ____________________ Amount: __________ Month: __________

Vendor Billing Address: ______________________________

2. ____________________ Amount: __________ Month: __________

Vendor Billing Address: ______________________________

3. ____________________ Amount: __________ Month: __________

Vendor Billing Address: ______________________________

Please note that 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 Aid's Pink Purse

SECTION C: (continued)

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

____

____

____

____

COMPLETED APPLICATION AND APPROPRIATE DOCUMENTATION SHOULD BE SUBMITTED TO:

EMAIL: thepinkpurse@pinkaid.org

FAX: 203. 291. 0121

MAIL: PINK PURSE
P.O. BOX 5157, WESTPORT, CT 06881

Please email JacquelineM@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: ____

Signature: ______________________________ DATE: ____________________