PINK AID'S PINK PURSE

Direct Assistance for Breast Cancer Patients

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 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.
- For Applicants residing OUTSIDE Connecticut and Long Island, NY; Pink Aid will fund up to $500 per applicant, once during a twelve-month period on behalf of qualified patients.
- All applications must be submitted through their Social Worker, Nurse Navigator or 501c3 Administrator. We are unable to review any applications submitted directly by a patient at this time.

Required documentation for an application to be eligible for funding:

- A signed letter from doctor on his/her letterhead confirming breast cancer diagnosis including date of latest treatment
- A signed letter from a Nurse Navigator, Hospital Social Worker or 501c3 Administrator verifying the patient has been screened and qualifies for financial assistance.
- A current and accurate billing statement/invoice that supports the month being requested for funding and the complete address to which payments are sent.
- Bill requested must be for the patient's place of residence
- If requesting a rent payment, we require and prefer a current lease. If a lease is not available, please use our ***Proof of Residency Form*.**

**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.*

NOTE: If you reside outside of CT or Long Island, NY and your household income is not 200% below the federal poverty level based on last year's federal tax return, unfortunately we will not be able to provide financial assistance to you at this time.

Today's Date

Month Day Year

Patient Information

Name

First Name | Middle Name | Last Name

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Phone Number

Area Code | Phone Number

Email

example@example.com

Marital Status

- ○ Single
- ○ Married
- ○ Separated
- ○ Divorced
- ○ Widowed

Primary Language Spoken

Are you currently employed

- ○ Yes
- ○ No

Other household members in your home that contribute to monthly expenses

Separate members by comma

Are you receiving social security disability?

- ○ Yes
- ○ No

Is your household income 200% or less of the federal poverty level based on last year's federal tax return?

- ○ Yes
- ○ No

If yes, list occupation

Is your household income 500% or less of the federal poverty level based on last year's federal tax return?

- ○ Yes
- ○ No

Is Aromatase Therapy or Hormonal Therapy your only current therapy?

- ○ Yes
- ○ No

Is Aromatase Therapy or Hormonal Therapy your current treatment due to COVID-19?

- ○ Yes
- ○ No

How did you hear about Pink Aid? (optional)

- ☐ Social Worker
- ☐ Friend
- ☐ Online Search
- ☐ Social Media
- ☐ Event
- ☐ _____

Current Treatment

Date of Diagnosis

Month Day Year

Hospital/Treatment Center

If you had or will be having surgery for your breast cancer diagnosis, please provide date:

Month Day Year

If you are receiving chemotherapy treatments, please provide date of last treatment:

Month Day Year

If you are receiving radiation therapy, please provide date of last treatment:

Month Day Year

Further Information

To be completed by Social Worker, Nurse Navigator or Patient.

A signed letter from a doctor on his/her letterhead confirming breast cancer diagnosis including date of latest treatment and a signed letter from a Nurse Navigator, Hospital Social Worker or 501c3 Administrator verifying the patient has been screened and qualifies for financial assistance must be included with this application in order to be considered for compassionate, financial assistance.

Breast Cancer Physician

Nurse Navigator or Social Worker

Nurse Navigator or Social Worker Email

example@example.com

Nurse Navigator or Social Worker Phone Number

Area Code Phone Number

If the patient applied for Pink Purse in the past, please list date

Month Day Year

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.

First Bill

Include Vendor, Amount, Month and Vendor Billing Address

Second Bill

Include Vendor, Amount, Month and Vendor Billing Address

Third Bill

Include Vendor, Amount, Month and 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.

ATTACH APPROPRIATE DOCUMENTATION:

- A signed letter from doctor on his/her letterhead confirming breast cancer diagnosis including date of latest treatment
- A signed letter from a Nurse Navigator, Hospital Social Worker or 501c3 Administrator verifying the patient has been screened and qualifies for financial assistance
- A current and accurate billing statement/invoice that supports the month being requested for funding and the complete address to which payments are sent (Bill requested must be for the patient's place of residence)
- A current lease or our Proof of Residency Form, if requesting a rent payment

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

Sign and print your name below

Printed Name

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.

COMPLETED APPLICATION AND APPROPRIATE DOCUMENTATION SHOULD BE SUBMITTED TO:
EMAIL: pinkpursect@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.