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.

Pink Purse Fund considers the following but not limited to as **Critical Non-Medical Household Expenses**:

- Utilities (i.e. electricity, heat, gas and hot water)
- Phone and Cable
- Transportation to and from hospital visits and treatment centers to include Uber gift cards, gas gift cards, car loan payments and car insurance premiums
- Rent or Mortgage (At this time, we are ONLY accepting requests for Connecticut and Long Island, NY patients)

Eligibility

All applications are required to be submitted by a Patient/Nurse Navigator, Social Worker or 501c3 administrator. Our policy is to work solely with a patient's social worker, we do not work directly with patients.

Today's Date

State of Residence

Is the patient in active treatment? Active treatment, for the purposes of Pink Aid's Pink Purse, 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 bilateral mastectomy, lumpectomy), chemotherapy or radiation. Active treatment does not include long-term hormonal therapies such as Tamoxifen or an Aromatase Inhibitor.

☐ Yes ☐ No

Is the patient's household income 300% or less of the FEDERAL POVERTY LEVEL based on last year's federal tax return? *

☐ Yes ☐ No

Persons in Family/Household	Poverty Level Income	300% Threshold for Pink Purse Eligibility
1	13,590	40,770
2	18,310	54,930
3	23,030	69,090
4	27,750	83,250
5	32,470	97,410
6	37,190	111,570
7	41,910	125,730
8	46,630	139,890

Patient Information

Name

Address 1

Address 2

City | State | Zip Code

Phone Number | Email

Date of Birth | Primary Language Spoken

Pink Aid hopes to better understand the patients we serve by gathering information about race and ethnic identity. Information that we obtain may be used to seek out additional funding to serve more patients through our Pink Purse Initiative. We hope you can help us by answering the following question below. Which of the following best describes you:

- ☐ Asian or Pacific Islander
- ☐ White or Caucasian
- ☐ Black or African American Hispanic or
- ☐ Multiracial or Biracial Hispanic
- ☐ Latino
- ☐ A race/ethnicity not listed here
- ☐ Native American or Alaskan Native
- ☐ Do not wish to answer

Marital Status

- ☐ Single
- ☐ Separated
- ☐ Widowed
- ☐ Married
- ☐ Divorced
- ☐ Do not wish to answer

Number of children under the age of 18 living in your household

Are you currently employed? ☐ **List your occupation:**

How did you hear about Pink Aid?

- ☐ Social
- ☐ Online
- ☐ Event
- ☐ Worker
- ☐ Social Media
- ☐

Required Documentation

Please review the additional documentation required to submit an application.

Note that all payments are paid directly to the vendor, we do not pay patients directly. Incomplete applications will not be considered for review. At this time, Connecticut and Long Island, NY residents may receive up to $1,000 in a twelve month period and all other patients may receive up to $500 once in a twelve month period. Applications can only be accepted in English.

Required at the time of submission:

1. A completed application signed by a Nurse Navigator, Hospital Social Worker or 501c3 Administrator.
2. A signed letter from a doctor on hospital letterhead confirming breast cancer diagnosis/active treatment.
3. A signed letter from a Nurse Navigator, Hospital Social Worker or 501c3 Administrator verifying the patient qualifies for financial assistance.
4. A billing statement dated within 30 days of this application and must relate to the patient's place of residence.
5. A current lease or Proof of Residency Form is required for rent requests.

Prioritize Bills in Order of Importance

First Bill

Vendor Name, Address and Amount Requested for Funding

Second Bill

Vendor Name, Address and Amount Requested for Funding

Third Bill

Vendor Name, Address and Amount Requested for Funding

If Requesting Transportation Requests:

Uber Card

Gas Card

If requesting gas card, provide the station address

Nurse Navigator/Social Worker Information

Current Treatment

Date of Diagnosis

Hospital/Treatment Center

If the patient will be having surgery for their breast cancer diagnosis, please provide date:

If the patient is receiving chemotherapy treatments, please provide date of last treatment:

If the patient is receiving radiation therapy, please provide date of last treatment:

Further Information

Breast Cancer Physician Name

Nurse Navigator or Social Worker Name

Nurse Navigator or Social Worker Email

Nurse Navigator or Social Worker Phone

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

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

All applications are required to be submitted by a Patient/Nurse Navigator, Social Worker or 501c3 administrator. 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.

Name of Nurse Navigator or Social Worker

Signature

Although we encourage you to submit your application online, you can also scan your application and supporting documents to: pinkpursect@pinkaid.org or mail to Pink Aid, PO Box 5157, Westport, CT 06881.