



# PINK AID'S PINK PURSE

*Direct Assistance for Breast Cancer Patients*

This application is for patients who reside outside of Connecticut and Long Island, New York

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

## Eligibility

All applications are required to be **SUBMITTED BY a Certified 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 500% of the FEDERAL POVERTY LEVEL based on last year's federal tax return?**

\*

Yes

No

Persons in Family/Household	500% Threshold for Pink Purse Eligibility
1	75,300
2	102,200
3	129,100
4	156,000
5	182,900
6	209,800
7	236,700
8	263,600

## 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 Worker

Online

Event

Patient

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, qualified patients may receive up to \$500 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 Hospital Social Worker, Nurse Navigator, Certified Patient Navigator 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 Hospital Social Worker or Nurse Navigator on hospital letterhead 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. A screenshot of an account balance is not an acceptable form of documentation and we require the full statement or bill.

### Please identify your bill of priority below:

#### Bill Detail

Vendor Name, Address and Amount Requested for Funding

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**If your patient could benefit from a transportation gift card grant, select one of the following. Note: we can only fund transportation requests directly associated with travel to and from breast cancer treatment with a maximum funding of \$200 in Uber or Gas Cards. Gift cards and be considered along with a patient's bills.**

Uber  
Gift Card

Exxon/Mobil  
Gas Card

Shell  
Gas Card

Speedway  
Gas Card

**Please explain why transportation assistance is needed:**

## **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 Certified Patient/Nurse Navigator, Hospital 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. Disclaimer: The Required Documentation Section above contains the complete list of the documentation required for this application. Any other documentation submitted that is not listed in the Required Documentation Section is not necessary for Pink Aid to make a determination and will be deleted from our files.**

**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](mailto:pinkpursect@pinkaid.org) or mail to Pink Aid, PO Box 5157, Westport, CT 06881.**