pinkaid

Emergency Financial Assistance

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

Pink Aid's Emergency Financial Assistance (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 our Pink Purse is open Monday – Thursday 9am-5pm EST and Friday 9am-12pm EST. Please do not submit applications after business hours as our system will not recognize and/or accept the application and therefore will not be reviewed. Kindly submit applications during our open hours as the pink purse is here to help.

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

Note if the patient's household income is **300% of the Federal Poverty Level, based on last year's federal tax return, they may be eligible for the Compassion Plus Award (CPA). The CPA is for the most dire breast cancer patients in active treatment and who would benefit from mortgage/rental assistance.

If you choose this award you may NOT also apply for the regular Pink Aid grant for household expenses. Patients are only permitted to choose one of these applications per 12 month period.

Please click **HERE** for the application or copy this link into your browser: **https://form.jotform.com/241285205796159** *

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, please note the following:
   a. must relate to the patient's place of residence
   b. if there is an additional name on the bill, please explain their relationship to the patient
   c. a complete address to which payments are to be sent
   d. minimum bill amount of $100
   e. we fund ONE BILL ONLY so please be sure to submit a bill that is the closest to our maximum $500
   f. a screenshot of an account balance is not an acceptable form of documentation and we require the full statement or bill.

Vendor Name, Address and Amount Requested for Funding

Bill Detail

Vendor Name, Address and Amount Requested for Funding

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. GAS cards can ONLY be considered along with a patient's request and bill FOR A CAR LOAN OR CAR INSURANCE PAYMENT.

☐ 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

Diagnosis (stage 1, stage 2)

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.

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.