Power 4 Pink Incorporated

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501(c)3 charitable organization

Application for Financial Assistance for Breast Cancer Treatment

Your Fight is Our Fight

Power 4 Pink is a non-profit 501(c)3 organization whose purpose is to form a relationship between healthcare professionals and the residents of Lorain County, including the entire City of Vermilion, who are diagnosed with breast cancer to ensure that those residents receive the necessary education, resources, and care to enjoy a healthy life. All applications are reviewed by the Power 4 Pink Board of Directors. **Funds are limited and based on availability.**

- Applicant must be a Lorain County resident to apply for assistance.
- **Applicant must be in current, active breast cancer treatment.**
- Application must be filled out completely, with all necessary verification paperwork enclosed.
- Applications received by the end of the month will be reviewed at the next month's meeting.

Section 1: Client Information

Name:_____Date: _____
Address:_____D.o.B.:_____
City: _____Zip Code:_____County:_____State:_____
Phone number:_____Alternate phone number: _____
Email: _____

Spouse:_____D.o.B.:_____
Address:_____
City: _____Zip Code:_____County:_____State:_____
Phone number:_____Alternate phone number: _____

Dependents:
Name:_____Age:_____D.o.B.:_____
Name:_____Age:_____D.o.B.:_____
Name:_____Age:_____D.o.B.:_____
Name:_____Age:_____D.o.B.:_____

Section 2: Health Insurance Information

Do you have Medicaid, Medicare or any other medical insurance? Yes No
If yes, please list all: _____
_____
_____

Section 3: Assistance Request (circle all that apply)

I need financial assistance with the following cancer treatment-related expenses:
Gas Card Medications Medical Co-Payments Breast Prosthetics
If you wish to request other treatment related expenses please define below:
_____
_____

*****Please provide copies of any previously paid qualifying expenses that you are requesting reimbursement for.

Section 4: Financial Information

Are you currently employed: (circle one) Yes No
Current employer: _____Occupation: _____
Employer address: _____

Work status: (full time, part time, etc):_____
Income Sources: (circle all that apply)
Social Security Insurance Public Assistance Disability Pension
UnemploymentOther _____
_____

Your monthly household net income: _____
Spousal monthly household net income:_____

Please provide verification of income (last 3 current paystubs) and a copy of last year's Tax Return.

SECTION 5a: MEDICAL INFORMATION & H.I.P.P.A. RELEASE

I,_____ hereby authorize any health care provider, hospital, doctor, and/or insurance company to release to Power 4 Pink Incorporated and its agents and employees any and all information contained in my patient records as they deem necessary and appropriate for the purpose of reviewing my Application for Financial Assistance for Breast Cancer Treatment.

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

I further understand that this consent is subject to revocation at any time except to the extent that action has been taken thereon. This authorization and consent will expire in one year from the date of the authorization unless expressly revoked by me.

I further understand that I have the right to revoke this authorization at any time and that if I revoke this authorization, I must do so in writing and present my written revocation to Power 4 Pink Incorporated. I understand the revocation will not apply to information that has already been released in response to this authorization.

I further understand that authorizing the disclosure of this health information is voluntary and that I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and I agree to hold-harmless and indemnify Power 4 Pink as well as its agents and employees from any disclosure or re-disclosure of information, authorized or unauthorized, accidental or intentional.

READ, UNDERSTOOD & APPROVED:

_____ DATE:_____
Applicant Signature

Section 5b: Medical Information [must be completed by your healthcare professional]

Date of Diagnosis: _____Diagnosis:_____
_____
_____
_____
Any re-occurrence: _____
Is client currently in treatment: (circle one) Yes No
Type of treatment:_____
_____
When is client scheduled for follow-up?_____

Healthcare Professional Information:
Doctor:_____Hospital:_____
Address:_____
City, Zip:_____
Phone Number: (___)_____Fax Number: (___)_____

Signature of Healthcare Professional:_____Date: _____
Print name of Healthcare Professional:_____

APPLICATION RELEASE

- I understand that the information provided on this application will be used solely for the purpose to determine financial assistance and will be kept confidential.
- I understand that any copies of financial information submitted with the application will not be returned.
- I understand that filling out the application will not guarantee or promise that any financial assistance will be provided.
- I understand that any falsification of information provided, may result in reversing the approval decision and I will be responsible for the full reimbursement of allocated funds and all legal fees incurred to the Power 4 Pink Organization.

By signing this application, I confirm that all of the information provided is true and accurate, and I agree with the above stated release.

_____ _____
Applicant's Signature Date

_____
Print Applicant's Name