

# Power 4 Pink Incorporated

P.O. Box 1034  
Amherst, Ohio 44001  
440-654-3487 (recorder)

[www.power4pink.com](http://www.power4pink.com)

501(c)3 charitable organization

Financial Assistance Application for Breast Cancer  
Treatment for household income that is equal to or  
lower than 300% of Federal Poverty Guidelines



## *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.: _____

Add'l Authorized Backup Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**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  
Unemployment Other \_\_\_\_\_

Your monthly household gross income: \_\_\_\_\_

Spousal monthly household gross 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:

\_\_\_\_\_  
Applicant Signature

DATE: \_\_\_\_\_

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