Power 4 Pink Incorporated

501(c)3 charitable organization
P.O. Box 1034
Amherst, Ohio 44001
440-654-3487 (recorder)

Application for Financial Assistance for Breast Cancer Treatment

Your Fight is Our Fight

Power 4 Pink Inc. is a 501(c)3 non-profit organization whose purpose is to form a relationship between healthcare professionals and the residents of Lorain County, 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 currently be in breast cancer treatment.
- Applicant needs be a Lorain County resident to apply.
- Applicant's household gross income must be below 300% of the poverty level.
- Application must be filled out completely, with all verification paperwork enclosed.
- Application should be mailed to our post office box. Or call and we will arrange for pickup. DO NOT email your application.

Section 1 : Client Information

Name: _____ D.O.B: _____

Address: _____

City: _____ State: ___ Zip: _____ County: _____

Ph# _____ Alternate Ph# _____

Email: _____

Spouse: _____ Ph# _____

Address (if different): _____

City: _____ State: _____ Zip: _____

Dependents: Name: _____ Age: __

Name: _____ Age: __

Name: _____ Age: ____

Person you wish to authorize as a backup contact:

Name: _____ Ph# _____ 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 breast cancer treatment related expenses:

Gas Cards Medications Medical Insurance (Premiums or Co-Pays)

Prosthetics Wigs Bra's Compression Sleeves Parking/Tolls

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: _____ Ph# _____

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 gross income: _____*

Spouse monthly gross income: _____*

Dependent(s) monthly gross income: _____*

Please provide verification of income (last 3 current paystubs) and a copy of last year's Tax Return and W2's.

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]

Patient Name: _____

Date of Diagnosis: _____Diagnosis:_____

_____

_____

_____

Any re-occurrence:_____

Is patient currently in treatment: (circle one) Yes No

Type of treatment:_____

_____

When is patient scheduled for follow-up?_____

Healthcare Professional Information:

Doctor:_____Hospital:_____

Address:_____

City, Zip:_____

Ph# (___)_____Fax# (___)_____

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 Inc. 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