## 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. <u>DO NOT</u> email your application.

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Section 1 : Client Info				N O D:
				D.O.B:
Address:	State:Zi	in:	Country	<del></del>
	StateZi Alternate Ph#			
	Arremate rith			
Spouse:				Ph#
Address (if di	fferent):			
				Zip:
Name: _			Age	2;
Person you wish to au	thorize as a backup con	ntact:		
				Relationship:
Section 2: Health Insu	urance Information			
Do you have Medicaid	l, Medicare or any othe	r medical ii	nsurance?	Yes No
If yes, please list all:				
Section 3: Assistance	<u> </u>			
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## 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

DATE:

unauthorized, accidental or intentional.

READ, UNDERSTOOD & APPROVED:

**Applicant Signature** 

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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: Hosp		
Address:		
City, Zip:		
Signature of Healthcare Professional:Print name of Healthcare Professional:		
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