Date Received at Foundation: ____________________

Think Pink ID: ____________________

THINK PINK FOUNDATION
ASSISTANCE REQUEST FORM

Information supplied to Think Pink Foundation will be held in the strictest confidence. In order to be considered for assistance, this form must be completed in its entirety and returned to Think Pink Foundation. Please print clearly and legibly.

Think Pink Foundation reserves the right to request additional information if deemed necessary. Submitting this application does not guarantee approval.

Date of Application: ____________________

Applicant Name: ____________________ SSN: ____________________

DOB (mm/dd/yyyy): ____________________ US Citizen: YES NO

Home Address: ____________________ City: ____________________

Zip: ____________________ County: LUZERNE*

*must be a Luzerne county resident for at least 6 months to be considered

Home Phone: ____________________ Work Phone: ____________________

Cell Phone: ____________________ Email: ____________________

Names and Ages of Children:

Name: ____________________ Age: ________

Name: ____________________ Age: ________

Name: ____________________ Age: ________

Name: ____________________ Age: ________

Primary reason for request:

________ Assistance with insurance co-pays

________ Assistance with travel expenses

________ Assistance with child care expenses

________ Assistance with housing expenses

________ Assistance with prescriptions/medications

________ Assistance with out of pocket cost of treatments

________ Other: ____________________

How did you hear about Think Pink Foundation?

________ Website

________ Newspaper article

________ Doctors office referral

________ Word of mouth/friends

________ Other: ____________________

Applicant: ____________________

What is your diagnosis?

____

____

When were you diagnosed?

____

____

What is your current treatment plan:

____

____

One of the criteria we have established for eligibility of funds is to demonstrate a financial need for our assistance.

The following answers will be used to help us make that determination. What are your monthly household expenses? (approximately)

________ **Rent/Mortgage**
________ **Transportation/Fuel**
________ **Food**
________ **Utilities**
________ **Medications**
________ **Child Care**
________ **Phone**
________ **Other**

What are your sources of income? Please check all that apply - do not indicate dollar amounts, only the source of your income at this time.

________ **Self**
- ________ **Salary**
- ________ **Savings**
- ________ **LT Disability**
- ________ **ST Disability**
- ________ **Pension/IRA**
- ________ **Unemployment**
- ________ **Sick/Vacation Pay**

________ **Other People that may be assisting you (parent, grandparent, child, sibling, etc)**
- ________ **Salary**
- ________ **Savings**
- ________ **LT Disability**
- ________ **ST Disability**
- ________ **Pension/IRA**
- ________ **Unemployment**
- ________ **Sick/Vacation Pay**

________ **Partner/Spouse**
- ________ **Salary**
- ________ **Savings**
- ________ **LT Disability**
- ________ **ST Disability**
- ________ **Pension/IRA**
- ________ **Unemployment**
- ________ **Sick/Vacation Pay**

Applicant: ______________________

Release of Information and Authorization

I have read Think Pink Foundation's guidelines and eligibility criteria and I declare that the information furnished and enclosed on this application is true and accurate to the best of my knowledge.

I hereby give my permission that this application and all the information provided be sent to Think Pink Foundation and the referring medical health professional. I understand that all applications will be reviewed on a case-by-case basis and final determination of any award will be made by the Recipient Review Committee and Board of Trustees of the Foundation.

I understand that there is a dollar limit to the amount of services I may receive throughout my lifetime of $3,500.00, as long as funds in the Foundation are available. I also understand there are no promises or guarantees that any award will be provided to me by the Foundation.

I understand that, in most cases and when possible, all awards will be paid to a third party provider (i.e. physician, insurance carrier, facility, utility company, etc) and not to me personally.

I declare that to the best of my knowledge, I meet all the following criteria:

________ **Resident of Luzerne County PA for at least 6 months;**

________ **Female, with a child or children, under the age of 18**

________ **Have been diagnosed by a licensed, reputable physician with a form of cancer within the past 6 months and am currently undergoing treatment for that cancer or have within the past 6 months;**

________ **Can demonstrate financial need for assistance**

________ **Can submit this application/explanation of how I am being affected and how the foundation's assistance can benefit my situation.**

________ **Can provide a letter/recommendation from a licensed physician**

________ **Complete a brief interview with a random member of the Foundation's trustees.**

IF ANY INFORMATION I HAVE PROVIDED PROVES TO BE UNTRUE, I UNDERSTAND THINK PINK FOUNDATION MAY TAKE WHATEVER ACTIONS MAY BE NECESSARY AND APPROPRIATE, INCLUDING BUT NOT LIMITED TO RETRACTION OF FUTURE AWARDS, REQUEST FOR RETURN OF ANY FUNDS PREVIOUSLY AWARDED TO ME, AND POSSIBLY LEGAL ACTION.

______________________________________ ____________________

Applicant Signature **Date**

PLEASE DO NOT WRITE BELOW THIS LINE- FOUNDATION USE ONLY

Application received by: ____________________

Date: ______________

Notification sent to application confirming receipt of information: ______________

Interview scheduled: ______________

Foundation trustee member completing interview: ____________________

Date interview completed: ____________________

Award requested: ____________________

Award approved: ____________________

Date: ____________________

Applicant notified:

Applicant: ______________________

YOUR STORY

Think Pink Foundation Board of Trustees has no way to know you except through this application.

We understand that this will not paint a complete picture of who you are and what you are experiencing at this point in your life.

On the lines below, please tell us about yourself, your diagnosis, need, or any other information that you feel may help us get to know the real you. Please help us understand your request and how it will affect you. Use additional pages if necessary.

Applicant: ______________________

MEDICAL RELEASE AND AUTHORIZATION

Federal Law protects the privacy and confidentiality of an individual's medical records. In order for Think Pink Foundation to access your medical records (as part of our award process), a Release and Authorization Form must be completed and submitted to your health care provider. Think Pink Foundation will only view, or ask to view, medical information that may be needed to clarify, support, or explain the medical diagnosis or treatment plan, or financial burden, that you are reporting to the Foundation.

I hereby authorize my health care provider to release any health care and billing information regarding my cancer treatment diagnosis, prognosis, etc. to Think Pink Foundation. The purpose of this request is to assist the Foundation in determining my eligibility for assistance. This Release and Authorization shall expire 12 months (twelve months) from its execution, if not revoked prior to the expiration of the 12 month period.

I, the undersigned, hereby request and give permission to:

____
Name of Health Care Provider

to release all medical/financial information from the record of:

______________________	____________	____________
Name of Patient	**DOB**	**SSN# (last 4)**

____
PRINT NAME

______________________________________	____________
Signature of Patient	**Date**

Applicant: ______________________

PUBLICITY RELEASE

Think Pink Foundation holds events and fundraisers throughout the year to fund the primary objective of the Foundation - to assist women like yourself. On occasion, reporters and/or publishers come to the Foundation for stories about our recipients- about you.

We need your assistance in making this happen. We ask your permission to use your photo, story, and a brief description of how the assistance you received from Think Pink Foundation has helped you.

This will assist us in communicating to our donors and help in attracting more contributors so that we can help more women.
Please indicate your permission by checking the appropriate area:

_______ **use of photo**
_______ **your background information**
_______ **your first name**
_______ **your first and last name**

UNDER NO CIRCUMSTANCE WILL ANY THINK PINK FOUNDATION TRUSTEE DIVULDGE ANY PERSONAL MEDICAL INFORMATION NOR WILL ANY TRUSTEE DIVULDGE ANY FINANCIAL INFORMATION YOU PROVIDED TO US TO ASSIST IN SELECTING YOU AS A RECIPIENT.

Permission to use the checked information above is given to Think Pink Foundation for use in PR/Marketing materials which will include, but not be limited to, Annual Reports, Newsletters, Website, Brochures, Advertisements, and any other promotional materials.

_______ **NO I prefer Think Pink Foundation not use my personal information in their publicity efforts and wish to remain annonymous.**
I understand this will not have any bearing on my eligibility for or selection of assistance from the Foundation.

____
PRINT NAME

______________________________________ ______________
Signature of Applicant **Date**

 Confidential