APPLICATION CHECKLIST

We encourage you to apply as soon as possible as it may take up to 90 days for your application to be processed. Please **check off** each item enclosed with your application. **All items are required. Incomplete applications will not be funded.** Applications sent by fax or email will not be accepted.

Mail completed application & all documents to: The Pink Fund, PO Box 603, Bloomfield Hills, MI 48303

For help with this application, please go to https://www.pinkfund.org/application-faqs/ for our detailed instructional videos, which are available for each page of the application and for each document we require. If you have any further questions, please email us at grants@thepinkfund.org.

Pages 1, 2 & 3

Personal Information

- ☐ Application checklist (this page)
- ☐ Application for Financial Assistance Form
- ☐ HIPAA Privacy Authorization Form
- ☐ A copy of your driver's license or state issued picture ID
  (Please note: the address on your ID must match the address on your application form.)
- ☐ A signed and dated letter from the employer(s) you had at the time of your diagnosis (on company letterhead), verifying your current employment or leave status in comparison to your pre-diagnosis status

Pages 4 & 5

Medical Information

- ☐ Medical Information Form *Cannot be self-completed.*
- ☐ Medical Team Contact Information Form
- ☐ A signed and dated letter* (on letterhead) verifying your diagnosis and detailing your current and upcoming treatment plan from one of the following: Oncologist, Licensed Social Worker, Patient Navigator, Nurse Navigator
  (Please include an email address for your Social Worker, Patient Navigator or Nurse Navigator)

Page 6

Financial Information - Please DO NOT send originals

- ☐ Financial Disclosure Form
- ☐ The first 2 pages of your federal tax return from the previous year
  If you are married or partnered, include the return for your spouse or partner.
- ☐ W-2's, 1099's or Schedule C's from the same year as your tax return
- ☐ A copy of your last 2 paycheck stubs for you and your spouse or partner
- ☐ A complete copy of all your checking and savings account statements for the last 2 months for you and your spouse or partner
- ☐ **Copies** of ALL bills you wish considered for payment.
  The bills must show your name, or the name of a listed household member, your current address, the account number, the current balance due, and the complete address to which payments are mailed.
  ***IF YOU RENT**, you must send a complete copy of your lease/rental agreement, including the name and complete mailing address of the person or agency to which payments can be mailed.*
  Bills considered for payment: Car Insurance Premiums, Car Loans, Health Insurance Premiums, Mortgage/Rent, Phone Bills, Utility Bills

The Mary Herczog Fund

To apply for **The Mary Herczog Fund** for Metastatic Breast Cancer, please also include:

- ☐ Social Security Benefit Verification Letter

Application submitted → Email / Mail notification of received application with timeline → Application reviewed (60 - 90 Days) → If missing documentation, incomplete, or ineligible for funding applicant will be notified → Complete & eligible applications presented to Qualification Committee for review (monthly) → Applicant notified of Qualification Committee's decision

The Pink Fund is not an emergency fund and cannot provide immediate assistance. We must have a current email address at which to contact you. If you do not have an email address, our communications will be through U.S. Mail which will delay the processing of your application.

Personal Information

The PINK FUND
REAL HELP NOW

Application for Financial Assistance

Name: _____ Date of Birth: ____/____/____

Street Address: _____ Ethnicity: _____ (Optional)

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

Email: _____ Phone: (____) _____ - _____

Educational Level: ☐ Post-Graduate ☐ College Degree ☐ High School ☐ Grade School

Marital Status: ☐ Single ☐ Living together ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please list all the people in your household:

Name:	Relationship:	Wage Earner: (Y/N)	Age:
	Self		

How did you hear about The Pink Fund? _____

Employment Information:

Company Name: _____

Employment Status before your breast cancer diagnosis:

☐ Full-time ☐ Part-time ☐ Unemployed

Date you last worked: ____/____/____

Current Employment Status:

☐ Full-time ☐ Part-time ☐ Unemployed

☐ FMLA ☐ Disability/sick leave

If on disability/sick leave are you receiving any compensation? Yes / No

Health Insurance: ☐ None ☐ Medicare ☐ Provided by Employer/Spouse's Employer

☐ Private ☐ Medicaid ☐ COBRA

If you have been diagnosed with metastatic breast cancer, have you applied for Social Security Disability?
Yes / No

Have you included the verification letter from SSD with your application? Yes / No

Are you receiving Social Security Disability Insurance/SSDI? Yes / No

SSDI Start Date: ____/____/____

HIPAA Privacy Authorization Form

Please date HIPAA Privacy Authorization Form to expire at least 6 months after you apply with The Pink Fund.

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R., Parts 160 and 164).

AUTHORIZATION

I_____(print name) hereby authorize_____ (your treating physician or hospital) to disclose the protected health information described below to **The Pink Fund**.

EFFECTIVE PERIOD

This authorization for release of protected health information covers the period from _____ (**DATE**) to and through_____(**DATE**).

EXTENT OF AUTHORIZATION

I authorize the release of my protected health information only as it pertains to my breast cancer diagnosis and treatment.

This medical information may be used by **The Pink Fund** for the purpose of evaluating my eligibility for financial aid according to its guidelines or for other purposes as I may direct in writing.

This authorization shall be in force and effect until_____(**DATE**), at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature_____Date_____

Printed Name_____

Medical Information

Cannot be self-completed **For questions please email Grants@thepinkfund.org**

Please have this page filled out by your Oncologist, Licensed Social Worker, Patient Navigator or Nurse Navigator verifying your current diagnosis and detailing your treatment plan **including start and projected end dates.**

Form completed by:

• Oncologist • Licensed Social Worker • Patient Navigator • Nurse Navigator

Applicant Name: _____

Hospital: _____

Current Diagnosis:

Date Diagnosed: _____ Stage/Grade: _____

Type:

☐ In-Situ ☐ Invasive Ductal Carcinoma ☐ Inflammatory ☐ Recurrent Metastasis ☐ Paget's ☐ Other: _____

Genomic / Biomarker / Tumor Testing: ☐ Yes ☐ No ☐ Not Applicable

Test Used: _____

Lumpectomy Date: _____

Mastectomy Date: _____

Chemotherapy: Start Date: _____ Projected End Date: _____

Radiation: Start Date: _____ Projected End Date: _____

Other therapy or treatment details: _____

_____ _____

Signature Date Signed

_____ _____

Name (please print) Email

_____ _____

Title Phone

Medical Team Contact Information

Please provide the name, email address, **and** phone number for the following providers. We may contact them if we can't reach you or need further information.

	Social Worker		
	Navigator		

Please read the statements below and initial where indicated.

_____ **Initial** I understand The Pink Fund does not pay for medical expenses of any kind.

_____ **Initial** I am currently a breast cancer patient either recovering from a mastectomy/lumpectomy, and/or I am currently undergoing chemotherapy or radiation.

_____ **Initial** I give my full authorization and permission to The Pink Fund to obtain the necessary medical information to process my application.

_____ **Initial** I understand The Pink Fund may ask personal questions about my treatment and financial status; I agree to provide accurate answers.

_____ **Initial** I understand The Pink Fund will be performing a follow-up survey.

_____ **Initial** I understand The Pink Fund is not liable for any cost incurred in the submission of this application for financial support.

_____ **Initial** I understand my application will be held for 7 years in accordance with The Pink Fund's retention policy and **will not be returned**.

_____ **Initial** I understand that if I have falsified information on my application for funding or have withheld information regarding The Pink Fund's definition of active treatment or my employment status, I will be required to immediately reimburse The Pink Fund for any payments administered on my behalf. The Pink Fund reserves the right to suspend any further payments that I have been awarded.

Applicant's Signature:_____ Date: _____

Financial Disclosure Form

Detail	Total
Savings / Checking Account Totals	

Income	Self Monthly Income Before Diagnosis	Self Monthly Income After Diagnosis	Spouse Monthly Income Before Diagnosis	Spouse Monthly Income After Diagnosis
Monthly Wages				
Social Security Disability and/or State Disability				
Other: _____				
Other: _____				
Other: _____				
Disability policy benefits or sick pay from employer				
Money from friends, family, or fundraisers				
Total Monthly Income				

Please include a **COPY** of all bills you wish considered for payment. **DO NOT** send originals. To be considered for payment, the bills must show all of the following:

- Your name (or the name of a listed household member)
- Your current address
- The account number
- The current balance due
- **The complete address to which payments are mailed**

*IF YOU RENT, you must send a complete copy of your lease/rental agreement, including the name and **complete mailing address** of the person or agency to which payments can be sent.*

Expense	Monthly Amount	Copy of Bill Included	Expense	Monthly Amount	Copy of Bill Included
Mortgage/Rent			Home Insurance		
Auto Loan			Auto Insurance		
Health Insurance / COBRA			Life Insurance		
Utilities (gas, electric)			Child Support		
Internet / Cable			Other:		
Telephone			Other:		
Groceries			Total Expenses:		

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