APPLICATION INFORMATION, FORM AND CERTIFICATION

Mission Statement
The mission of Think Pink Monroe Inc. is to promote breast cancer awareness and education to the Monroe community, women and men, and by doing so, to save lives, as well as to offer support and encouragement, and inspire hope, to those individuals and families impacted by breast cancer.

In addition, our goal, through fundraising efforts, is to provide assistance, regardless of age, gender, race or religion, to Monroe families impacted by breast cancer.

How We Help
Financial assistance is granted to patients who meet Think Pink Monroe's criteria. These funds are used to offset expenses associated with breast cancer. Think Pink Monroe believes that by easing some financial burdens, the patient can focus on recovery. Think Pink Monroe is a 501(c)(3) nonprofit breast cancer organization. During the initial years of our establishment, maximum awards are $500.00 per calendar year depending on the availability of funding.

To be eligible for financial assistance, and for us to comply with the strict requirements of our nonprofit status, you MUST:

(1) Be a breast cancer patient currently or recently receiving treatment, and a resident of Monroe;

(2) Provide current proof of residency from two (2) different sources (acceptable forms: bills from mortgage, utility or credit card company; hospital or doctor bill; tax bill; driver's license or motor vehicle registration; passport; bank statement; Medicare/Medicaid benefit statement.)

(3) Provide proof of identification with a copy of a State of Connecticut or federal issued and unexpired photo identification (such as a driver's license or U.S. passport).

Please note: an Application is NOT a guarantee of receiving financial assistance. Funds are limited and based on eligibility and availability.

Please send your Application and accompanying documents to**: Think Pink Monroe Inc., 97 Bug Hill Road, Monroe, CT 06468** or by email to **thinkpinkmonroe@gmail.com**. All Applications MUST be received by the 20th of the month in order to be considered at the following Think Pink Monroe Board meeting. You will receive a response indicating whether your Application has been approved. Incomplete forms or those missing documents may delay the Application process.

Think Pink Monroe is required by law to protect your health information. By signing this document, you authorize Think Pink Monroe to use your health information for the sole purpose of determining eligibility for financial assistance. Think Pink Monroe needs these records to show we are fair and ethical in our application process and to make sure you meet the criteria of our mission statement.

I have read and understand the above statement.

Signature: _____ Date: _____

APPLICATION FOR FINANCIAL ASSISTANCE

Date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Full Address: _____

Phone number: Home: ( ) _____ Cell: ( ) _____

Email Address: _____ Date of birth: _____ Male/Female

If patient is a minor (under18), name of parent/guardian: _____

Signature of parent/guardian: _____

MEDICAL INFORMATION

Diagnosis: _____ Date of Diagnosis: _____ Current Stage: _____

Is patient in active treatment? Yes ____ No ____

To be eligible for financial assistance, patient MUST be a breast cancer patient currently or recently receiving treatment and be a resident of Monroe, Connecticut.

TREATMENT PLAN: Chemotherapy _____ Radiation _____ Surgery _____

Other (please be specific): _____

HEALTH CARE PROFESSIONAL INFORMATION:

Oncologist name: _____

Address: _____

Phone: ( ) _____ Fax: ( ) _____

***** PLEASE PROVIDE A MEDICAL RECORD, REPORT OR NOTE FROM YOUR ONCOLOGIST DOCUMENTING THAT YOU ARE IN CURRENT TREATMENT OR HAVE RECENTLY BEEN TREATED FOR BREAST CANCER. UNFORTUNATELY, WE ARE REQUIRED TO OBTAIN SAID DOCUMENTATION AS PART OF OUR NONPROFIT STATUS REQUIREMENTS. WE RESERVE THE RIGHT TO REQUEST ADDITIONAL DOCUMENTATION. YOUR APPLICATION AND ACCOMPANYING DOCUMENTS WILL BE HANDLED IN STRICT CONFIDENCE. INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED.**

FINANCIAL ASSISTANCE

We recognize that there are often large financial burdens related to any breast cancer diagnosis. While we are limited at this time to providing a maximum of $500 per patient, and we hope in future years to be able to increase this maximum amount, we hope that this assistance provides some relief to the patient.

Amount Requested: _____ ($500 maximum)

Please provide a description of what the assistance will be used for (ie. help with medical care/co-pays; utilities; household goods; etc):

_____

_____

_____

Please be aware that funds are limited and based upon availability, as well as on meeting Think Pink Monroe eligibility requirements. An application is NOT a guarantee of receiving financial assistance.

CERTIFICATION

I certify that the information in this Application is true and complete to the best of my knowledge.

Signature: _____ Date: _____

For any questions, please reach out to us either at thinkpinkmonroe@gmail.com or by calling Bonnie Maur, Board President, at 203.339.1753