United *in* Pink

THE PINK BRIDGE

Bridging the Gap by Providing Financial Assistance
for Medical and Non-Medical Expenses
for Breast Cancer Patients in Active Treatment

Financial Assistance Application Packet

1415 Bass Road, Suite B

Macon, GA 31210

Email: finance@unitedinpink.org

Unitedinpink.org

UPDATED 08/2024

PROGRAM OVERVIEW

- The Pink Bridge Assistance Program is a Two-Step Process:
    - Step 1 is Eligibility Verification (can take up to 14 business days to process)
    - IF ELIGIBLE to proceed, Step 2 is Need Verification and Review (begins AFTER eligibility time period and can take up to 4 more weeks)
- United in Pink approves requests for limited medical and non-medical expenses.
    - Medical expenses include, but are not limited to:
        - surgical costs not covered by insurance but needed to complete the breast cancer treatment plan set by their Medical Team. (Excluding medications)
    - Non-medical expenses include, but are not limited to:
        - housing (rent or lease payments) and utilities (electricity, gas, propane, and water), and transportation expenses. (Excluding phone/cell/cable/internet and car payments & insurance)
- If Eligibility Criteria is met, the United in Pink selection committee will meet once a month to review accepted applications. Our application and review process may take 4-6 weeks.
- Requests will ONLY be reviewed once all documents, including bills, explanation of benefits, and medical reports are received. Incomplete applications will not be reviewed.
- The selection committee sets the eligibility criteria and has final determination in all cases.
- Assistance is granted on a first-come, first-serve basis to the extent funding is available.
- The Pink Bridge Program may only be able to assist a portion of the potential recipients who apply for aid.
- If approved, payment will be made directly to the vendor rendering services on behalf of the patient. No checks will be written to the applicant.
- United in Pink reserves the right to refuse service to anyone.
- Assistance will be terminated if any untrue or falsified information has been submitted.
- Upon award, funds shall be available for 90 days.
- Please understand we are not an emergency fund and cannot provide immediate assistance.
- Meeting the guidelines and applying to the Pink Bridge Program does not guarantee funds will be available or offered.
- Pink Bridge applications will not be returned once submitted.

Eligibility Criteria

All of the following must be met to be eligible to apply.

Eligibility to apply does not guarantee approval of application.

Please mark yes or no to the questions below

YES	NO	
		1. I am a United States Citizen
		2. I am a Georgia resident
		3. I reside in one of the following counties: Baldwin, Bibb, Bleckley, Butts, Coffee, Crawford, Dodge, Dooly, Hancock, Houston, Jasper, Jones, Lamar, Laurens, Monroe, Peach, Pulaski, Putnam, Spalding, Taylor, Twiggs, Upson, Wilkinson
		4. I have a breast cancer diagnosis and am in active treatment. *(Active treatment is the period after a positive breast cancer diagnosis and during which therapies are being administered – including single or bi-lateral mastectomy, lumpectomy, axillary dissection, sentinel node biopsy, chemotherapy, radiation. Active treatment does not include long-term hormonal therapies or reconstruction surgery revisions)*
		5. My active treatment status includes one of the following: chemotherapy, radiation, surgery, reconstructive surgery immediately following your active treatments.

If you marked "No" to any of the questions above, you are not eligible for Pink Bridge Funding at this time. Please visit unitedinpink.org for our list of additional resources that can be of assistance to you. We also encourage you to participate in other programs and services provided by United in Pink.

General Guidelines

- Patients must download, complete, and mail/submit the application. For the protection of your confidential information, all documents supporting your application must be MAILED or schedule an appointment for them to be DROPPED OFF.
    - We cannot accept an application via email.
- We do not accept originals of any bills, only copies.
    - *We are available to make copies. Please schedule an appointment with a United in Pink Staff Member if you need this service.*
- We do not accept print outs/screenshots from online accounts without full payment information.
    - All bills must have a phone number, website, and address for access to payment information.
- If you cannot provide a bank statement from a checking account or pre-paid debit account, your application will not be funded and denied.
- We do not require tax returns at this time.

The Pink Bridge Requirements

The Pink Bridge Program is a two-step process and can take 30-60 days for application consideration. This is not an emergency relief fund. These funds are designated to support financial hardships created by a breast cancer diagnosis and will not consider, or cover, debt incurred prior to diagnosis.

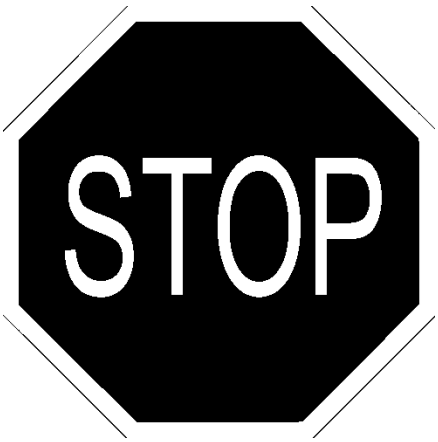
STEP 1: ELIGIBILITY VERIFICATION (takes up to 14 business days from receipt of completed items below)

Patients must submit the following:

- Financial Assistance Request Form (page 7).
- Financial Statement (page 10).
- Detailed Statement of Need (page 11).
- Medical Referral Form with Signature (page 12).
- Medical Health Information Release & Authorization Form (page 13).
- Last 2 pay stubs or proof of unemployment.
    - This shall include copies of any unemployment or stimulus payments.
- Bank statements from the last 2 months.
- If applicable, copy of Social Security or Social Security Disability Income, statement, or letter.
- Copy of driver's license or alternate ID (front and back).
- If insured: copy of current insurance, Medicare, and supplemental cards (front and back).
- If uninsured: copy of Medicaid and/or Social Security Disability rejection letters.

STEP 2: If eligible to proceed – a representative from United in Pink will reach out and request specific items that may include:

- Copy of bill(s) being submitted for payment.
- Copy of bill(s) relating to monthly expenses.
- Additional information as requested



ALL APPLICATIONS SHOULD BE MAILED OR DROPPED OFF TO:

UNITED IN PINK

THE PINK BRIDGE PROGRAM

1415 BASS ROAD, SUITE B

MACON GA 31210

IF YOU ARE DROPPING OFF AN APPLICATION, YOU MUST SET UP AN APPOINTMENT WITH A UNITED IN PINK STAFF MEMBER.

WE DO NOT ACCEPT WALK-INS.

The Pink Bridge Financial Assistance Request Form

For United in Pink Office Use Only:

Request Received: _____ By Whom: _____

Date of Application: _____

First Name_____ M.I._____ Last Name_____

Address_____ Apt.#_____

City_____ County_____ State_____ Zip Code_____

Date of Birth (MM/DD/YYYY) ____/____/____ Age___

Gender: Male___ Female___ Prefer not to Answer___

Home Phone (___)_____ Cell Phone (___)_____ Which do you prefer?

Email_____ ***REQUIRED (please print very clearly, we must communicate with applicants via email, so if we can't read your email address, you may not hear from us.)

Name of email account holder and relationship to patient (if not applicant):

_____

Patient Information:

1. Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Living Together
2. Total # of people living in household____

NAME	RELATIONSHIP TO APPLICANT	AGE	WAGE EARNER? (Y/N)	DO THEY CONTRIBUTE TO HOUSEHOLD EXPENSES? (Y/N)

3. Race/Ethnicity (*for data collection purposes only):* _____

4. Health Insurance: ☐Medicare ☐Medicaid ☐Individual insurance ☐Group insurance provided by an employer ☐Other (supplements or secondary) **check all that apply*
5. Are you currently employed?
   ☐Yes
   ☐No
6. Current Employment Status:

   ☐Full Time

   ☐Part Time

   ☐FMLA

   ☐Disability/Sick Leave

   ☐Unemployed

7. Did you work before your breast cancer diagnosis? ☐Yes ☐No
   If yes, what was your employment status?_____

8. Amount Requested: _____

   **Amount may not exceed $2500 and must have documentation/statements that support amount requested*

9. Type of support requested: ☐Medical ☐Grocery Assistance
   ☐Housing ☐Gas/Transportation Assistance
   ☐Utilities

10. How did you hear about United in Pink? _____
11. Have you spoken with a United in Pink representative? ☐Yes ☐No
12. Have you applied to this program before? ☐Yes ☐No

BREAST CANCER INFORMATION

1. Date of breast cancer diagnosis_____ (MM/YY)
2. Are you in current treatment? ☐Yes ☐No
3. Current Type of Treatment:
   - ☐Surgery (lumpectomy or mastectomy)
   - ☐Chemotherapy
   - ☐Radiation
   - ☐Reconstruction
4. Treatments in the last 12 months (*check all that apply*):
   - ☐Surgery (single or bilateral mastectomy, lumpectomy, axillary dissection, sentinel node biopsy)
   - ☐Chemotherapy
   - ☐Radiation
   - ☐Reconstruction

Monthly Financial Statement

Sources of Monthly Income	**Monthly Amount**	**Copy of Proof Included? (y/n)**
Your current monthly wages/salary (after taxes)	$	
Your spouse's/partner's monthly wages (after taxes)	$	
Property rental income (not your rent expense)	$	
Interest/Dividends	$	
Veterans Benefits	$	
Disability (State or employer)	$	
SSI/SSD/SS	$	
Unemployment Insurance	$	
Workers Comp	$	
Child Support/Alimony	$	
State/County Assistance	$	
Food Stamps	$	
Pension/Retirement	$	
Money from friends, family, or fundraisers	$	
Other	$	
Total of all Income (Monthly) ***(Please enter total)***	$	

Monthly Expenses	**Monthly Amount**	**Copy of Bill Included? (y/n)**
Rent or Mortgage (please circle one)	$	
Electricity	$	
Gas (home)	$	
Water	$	
Trash	$	
Cable/Internet	$	
Home Phone	$	
Cell Phone	$	
Food	$	
Auto Loan(s)	$	
Auto Insurance	$	
Gas (auto)	$	
Health Insurance Premium	$	
Medicines	$	
Internet	$	
Cable/Satellite/ Streaming	$	
School/Tuition	$	
Child Care	$	
Student Loans	$	
Other Loans	$	
Total Monthly Expenses ***(please enter the total)***	$	

I have examined the above statements and certify that, to the best of my knowledge, they are a full, true and accurate statement of fact. I understand that if I enter an amount I must submit documentation to verify.

_____ _____ _____

Signature Printed Name Date

Statement of Need

How has your breast cancer diagnosis affected you and your family, and why is there a need for financial assistance? What are your financial needs?

Please tell the committee about your cancer journey and the effects it has had on your household. This statement will be seen and evaluated by an anonymous committee. It is a chance for them to get to know you and understand your situation better.

[*Please type and attach your story or email separately to finance@unitedinpink.org]

United in Pink asks for your permission to share your story with others to help raise public awareness of the Pink Bridge Program, communicate to donors and the community to support the cause, and inform breast cancer patients, healthcare providers, and others about their services.

Yes, I will allow United in Pink to use:

☐First Name

☐All or part of your story (anonymously)

☐Services received.

☐Photo if provided.

☐Quote

☐NO, I do not give permission for UIP to use my personal information, images in publications, general media or materials.

I understand that my approval or denial of permission will in no way affect the assistance provided to me.

_____ _____

Patient Signature *Date*

Medical Referral Form *[to be completed by Medical Healthcare Professionals Only.]*

***Upon completion, please attach a letter on the treating doctor's letterhead indicating that this patient is currently receiving care for breast cancer.*

DATE _____

Patient Name _____

DOB: _____

Physician providing treatment: _____

Name of Practice: _____

Date of Diagnosis _____ (MM/YY)

Breast Cancer Type: ☐ Invasive Ductal Carcinoma ☐ Invasive Lobular Carcinoma ☐ Ductal Carcinoma in Situ (DCIS) ☐ Lobular Carcinoma in Situ ☐ Inflammatory BC ☐ Other (please specify)

_____

Breast Cancer Subtype: ☐ ER ____ + ____-, ☐ PR ____ + ____-, ☐ HER2 ____ + ____-, ☐ Unknown

☐ Other (please specify) _____

Oncotype: ☐ Positive ☐ Negative

ICD10 Code _____ Stage _____ Grade _____

Surgery: ☐Lumpectomy ☐Mastectomy ☐ Unilateral ☐ Bilateral Date: _____

Chemotherapy: ☐ Dates: _____

Neo-Adjuvant Chemo: _____, Post Surgical Chemo: _____

Radiation: ☐ Dates: _____

Reconstruction: ☐ Dates: _____

Please list any upcoming appointment dates if known: _____

Does your facility offer financial assistance? ☐ Yes ☐ No

If Yes, has the patient completed an application? ☐ Yes ☐ No

Other Information to include why this patient needs financial assistance (if known):

_____

_____

Print Name of Healthcare Professional: _____

Signature: _____

Medical/Health Information Release & Authorization Form

[To be completed by the Applicant]

In accordance with state and federal laws and to protect the privacy and confidentiality of an individual patient's medical records, this form must be completed by the applicant. In order for United in Pink to access and verify your medical information as part of your application for financial assistance, a Release and Authorization form must be executed and submitted to your health care provider(s).

I hereby authorize United in Pink to request, use, and disclose certain health care and billing information regarding my breast cancer diagnosis, treatment, and medical bills:

	Name	Location (*City*)	Phone Number
Primary Care Physician:			
Medical Oncologist:			
Surgeon:			
Radiation Oncologist:			
Plastic Surgeon:			

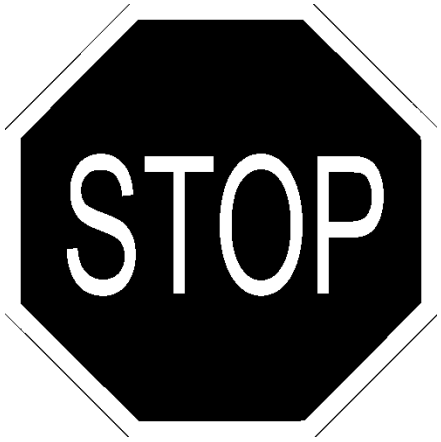
Information gathered/submitted will be used for the following purposes:

1. To assist United in Pink in determining eligibility for financial assistance through its Pink Bridge Program.
2. If awarded assistance, to pay funds toward qualified medical bills.
3. United in Pink will not receive payment or other renumeration from a third party in exchange for using or disclosing health information and will maintain privacy regarding personal health information.

This Release and Authorization will expire 12 months from its execution, if not revoked prior thereto. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to United in Pink, The Pink Bridge Program at 1415 Bass Road, Suite B, Macon, GA 31210.

Printed Name	Date of Birth	last 4 digits of SSN

Signature of Patient	Date



Please ensure that you have read and understood the Program Overview, Eligibility Criteria and Timeline, General Guidelines and Process, and Application Requirements before submitting this application.

An incomplete application can lead to a delay in consideration.

Please note that a United in Pink Staff Member will be in contact after receipt of this application.

You must complete an in-person or phone review of your application before review. A United in Pink team member will reach out once they have received STEP 1 items.

CHECKLIST

Please refer to this checklist as you complete this application.

☐ Financial Assistance Request Form (page 7).

☐ Financial Statement (page 10).

☐ Statement of Need/Your Story (page 11).

☐ Medical Referral Form with Signature (page 12).

☐ Medical Health Information Release & Authorization Form (page 13).

☐ Last 2 pay stubs or proof of unemployment. This shall include copies of any unemployment or stimulus payments.

☐ Bank statements from the last 2 months.

☐ If applicable, copy of Social Security or Social Security Disability Income, statement, or letter.

☐ Copy of bill(s) being submitted for payment.

☐ Copy of bill(s) relating to monthly expenses.

☐ Copy of driver's license or alternate ID (front and back).

☐ If insured: copy of current insurance, Medicare, and supplemental cards (front and back).

☐ If uninsured: copy of Medicaid and/or Social Security Disability rejection letters.

☐ Completed application mailed or dropped off to United in Pink.

☐ Please keep a copy of ALL items you are submitting to United in Pink.