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

Phone: 478.845.8271
Email: finance@unitedinpink.org
Unitedinpink.org

UPDATED 03/2024

PROGRAM OVERVIEW

- United in Pink approves requests for limited medical and non-medical expenses.
  - Medical expenses include, but are not limited to:
    - physician office co-payments
    - 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.
- United in Pink selection committee will meet once a month to review submitted applications. Our 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 and/or being treated 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
		5. My active treatment status includes one of the following: chemotherapy, radiation, surgery, reconstructive surgery, hospice, or palliative care

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 at this time.

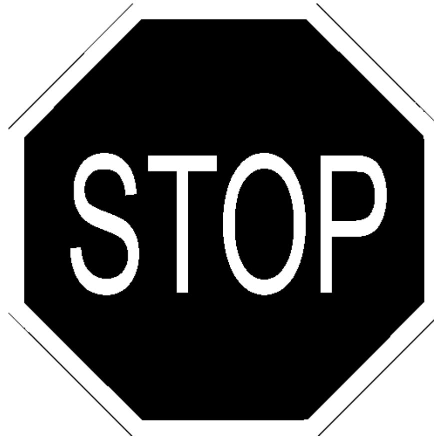
General Guidelines

- 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 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.
- Patients that have applied to The Pink Bridge before and received assistance must wait a full calendar year from the date of application and still be in active treatment to be eligible for assistance again.

The Pink Bridge Requirements

Patients must submit the following:

- 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.



ALL APPLICATIONS SHOULD BE MAILED OR DROPPED OFF TO:

UNITED IN PINK

THE PINK BRIDGE PROGRAM

1415 BASS ROAD, SUITE B

MACON GA 31210

478-845-8271

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 ☐Customized Care
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. First time breast cancer diagnosis: ☐Yes ☐ No

   If no and this is a metastasis, date of first diagnosis: ____________________ (MM/YY)
3. Are you in current treatment? ☐Yes ☐No
4. Current Type of Treatment:

   ☐Surgery (lumpectomy or mastectomy)

   ☐Chemotherapy

   ☐Radiation

   ☐Reconstruction

   ☐Hospice

   ☐Palliative Care
5. Treatments in the last 12 months (*check all that apply*):

   ☐Surgery (lumpectomy or mastectomy)

   ☐Chemotherapy

   ☐Radiation

   ☐Reconstruction

   ☐Hormone Therapy
6. Do you have an upcoming surgery date? ☐Yes ☐ No

   If yes, please list the date: ____________________ (MM/DD/YY)

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/Story

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

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- ☐ ER+/PR+/HER+ ☐ER+/HER2- ☐ER-/HER2+ ☐ Unknown ☐ Other (please specify) ____

Oncotype: ☐ Positive ☐ Negative

ICD10 Code __________________________ Stage _______ Grade _______

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

Chemotherapy: ☐ Dates: _______________________

Hormonal Therapy: ☐ Dates: _______________________

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.

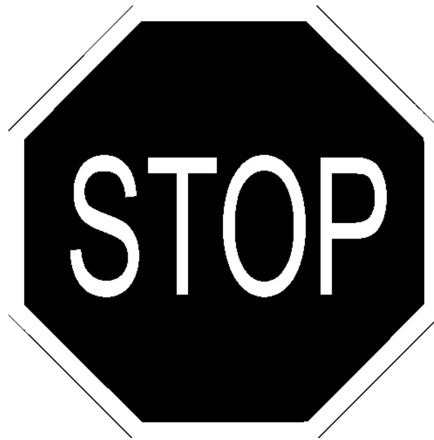
This Release and Authorization will expire 12 months from its execution, if not revoked prior thereto. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to United in Pink, 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, General Guidelines, and Application Requirements before submitting this application.

An incomplete application can lead to a delay in approval.

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.

The next page contains a checklist of all required materials for your convenience.

Please direct all questions to 478.845.8271.

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.