LINKED BY PINK MEDICAL GRANT

* The age limit has been temporarily increased to those diagnosed before the age of 55

****Please allow 4-6 weeks for processing of application and payments**

FINANCIAL ASSISTANCE OPTIONS (Check all that apply):

I am applying for the following grant(s):

❑Medical Grant – Up to $1000 ❑Transportation Grant – Up to $200 ❑Living Expense Grant – Up to $800

PATIENT INFORMATION (please print)

Today's date: _____

First name: _____ Last name: _____

Address: _____ City, State, Zip: _____

Phone number: Home ( ) _____ Work ( ) _____

Cell ( ) _____ Date of birth: _____

Email Address _____ ❑ I would like to be added to the LBP newsletter

HEALTH CARE PROFESSIONAL INFORMATION (please print):

This section must be completed by nurse, doctor, or social worker ONLY.

MD name: _____ Hospital/Clinic: _____

Address: _____ City, State, Zip: _____

Phone: ( ) _____ Fax: ( ) _____

NAME AND TITLE OF PERSON COMPLETING THIS SECTION, IF DIFFERENT THAN ABOVE (please print):

_____

Phone: ( ) _____ Email: _____

Is this treatment medically necessary? ❑Yes ❑No

Your relationship to person applying for help: ❑Doctor ❑Nurse ❑Social Worker ❑ACS Patient Navigator

MEDICAL INFORMATION

This section must be completed by nurse, doctor, or social worker ONLY.

Date of 1st diagnosis: _____ Age at 1st diagnosis: ____ Primary cancer: _____ Stage _____

Date of most recent diagnosis (if different)_____ Primary cancer: _____ Stage _____

Most recent diagnosis is: ❑New diagnosis ❑Recurrence

Is patient in active treatment active treatment? ❑Yes ❑No

Indicate Current Treatment ❑Chemotherapy ❑Radiation ❑Surgery

****Please Note: Hormonal Therapy is NOT considered active treatment**

Please indicate type of treatment(s) received in past twelve months (check all that apply)

❑Chemotherapy ❑Radiation ❑Surgery ❑Hormonal ❑Palliative care ❑Bone marrow/stem cell transplant ❑Physical therapy

If not in active treatment, indicate frequency of follow-up: ❑Yearly ❑Every six months ❑Other_____

Signature of MEDICAL PROFESSIONAL: _____ Date: _____

*** Form must be signed by health care provider in order to be considered**

THIS SECTION TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL GRANT:

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? ❑Yes ❑No

If yes, please indicate type of insurance (check all that apply):
❑Private insurance ❑Medicaid ❑Medicare ❑Medicare plus Medigap ❑Charity care ❑VA program

Who is your provider? _____

Are you choosing to go out of network for services? ❑Yes ❑No

Are prescription drugs covered? ❑Yes ❑No

ADDITIONAL INFORMATION

Is patient currently employed? ❑Yes ❑No Place of Employment _____

Marital Status _____ No. of people in household: _____ No. of adults: _____ No. of children: _____

HOUSEHOLD FINANCIAL INFORMATION

**** Stage IV (4) Patients do not need to provide financial information****

FAMILY INCOME SOURCES (please check all that apply):
❑Social Security (retirement) ❑Salary ❑Pension ❑Unemployment
❑Public assistance ❑Short-term disability ❑SSD (Disability) ❑SSI
❑Family/friends provide support ❑Other - specify _____

TOTAL ANNUAL FAMILY INCOME *: $_____ * Grant will not be processed if this information is not provided

Must enclose a copy of most recent income tax return * Grant will not be processed if this information is not provided

* You may attach supporting documentation/statement of extenuating financial circumstances

*** Grant will not be processed if the above information is not provided (Stage 0 – Stage 3 patients)**

Please be aware that funds are limited and based on availability.

Patients must also meet Linked By Pink's eligibility requirements.

PLEASE CHECK THE FOLLOWING BOXES

□ I live within a 45 mile radius of Erie, PA.

□ By checking this box, I am giving my full authorization and permission to Linked By Pink to obtain the necessary medical information to process my application.

□ I understand Linked By Pink may ask personal questions about my treatment and financial status if needed. I agree to provide accurate answers.

□ If approved, funds must be used within one year of approval, otherwise balance will be forfeited.

*If choosing Transportation Grant, please check where you would like your gift card from:

Country Fair_____ Kwik Fill_____

*If choosing Living Expense Grant

Please specify if you would like: Grocery card ____ or Rent/Mortgage/Utility Assistance _____

*For Grocery Card please check where you would like it from: Giant Eagle _____ Wegmans _____

*For Rent/Mortgage/Utility option we will need a copy of the lease/mortgage/utility payment coupon showing patient or spouse's name as well as the company or landlord's name.

Signature: _____ Date: _____

Relationship to patient: ❑Self ❑Spouse ❑Family member/caregiver ❑Health care professional

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****LBP will not be responsible for lost or misdirected mail.**

All information is strictly confidential and is for Linked By Pink use only.

For more information about Linked By Pink's monthly get togethers, information about the organization, upcoming events and/or additional programs available, please check out our Facebook page, our website at linkedbypink.org or email us at info@linkedbypink.org.

By applying for the grant, you have no obligation to participate in any Linked By Pink activities.