

## LINKED BY PINK MEDICAL GRANT

\* The age limit is currently open to those diagnosed before the age of 50.  
Please be aware that funds are limited and based on availability.

### FINANCIAL ASSISTANCE OPTIONS (Check all that apply):

I am applying for the following grant(s):

(\*Please note that those considered in active treatment are eligible to apply for all three grants, Active treatment consists of current chemotherapy, radiation, a new diagnosis, awaiting treatment or surgery, this does not include long-term hormonal therapy. Non-active applicants are eligible to only apply for the Medical Grant.)

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

Have you previously applied for a Linked By Pink grant?  Yes     No

### PATIENT INFORMATION (please print)

Today's date: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Phone number: Home (    ) \_\_\_\_\_ Cell (    ) \_\_\_\_\_

Date of birth: \_\_\_\_\_ Email Address \_\_\_\_\_

### HEALTH CARE PROFESSIONAL INFORMATION (please print):

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

Name of Provider: \_\_\_\_\_ 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

### MEDICAL INFORMATION

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

Date of 1<sup>st</sup> diagnosis: \_\_\_\_\_ Age at 1<sup>st</sup> 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?  Yes     No     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     Targeted     Immunotherapy     Palliative care

Bone marrow/stem cell transplant     Physical therapy

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 insurance provider? \_\_\_\_\_

**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)**

**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 \_\_\_\_\_ Get Go \_\_\_\_\_

\*If choosing Living Expense Grant, please specify if you would like:

Grocery card \_\_\_\_\_ Rent/Mortgage/Utility Assistance \_\_\_\_\_

\*For Grocery Card please check where you would like it from:

Giant Eagle \_\_\_\_\_ Wegmans \_\_\_\_\_

\*For Rent/Mortgage/Utility option please provide a copy of the lease/mortgage/utility payment invoice showing patient and/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

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

**\*\*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, website at [linkedbypink.org](http://linkedbypink.org) or email us at [info@linkedbypink.org](mailto:info@linkedbypink.org). By applying for the grant, you have no obligation to participate in any Linked By Pink activities.