Application for Financial Support

APPLICATION GUIDELINES:

1. Shades of Pink Foundation provides temporary financial assistance to individuals who are experiencing financial distress due to breast cancer. Expenses incurred prior to a breast cancer diagnosis are not eligible for assistance.
2. Applicants are eligible once/lifetime. If an application is returned as incomplete or is rejected, applicants can reapply, but their application will be reviewed based on the new application date.
3. Grants typically cover mortgage/rent, utilities, transportation costs including car insurance, COBRA or health insurance premiums. Medical expenses such as co-pays, prescription costs, deductibles, and medical bills including bills for doctor visits, diagnostic testing, treatment, recovery or reconstruction are not eligible.
4. Funding is limited and is based on availability and eligibility.
5. Requests must be made through the social worker, nurse, patient navigator, therapist or other medical personnel where the applicant receives care and they must complete Parts I, II, and III of the application.
6. Applicant must have been diagnosed within 12 months of application date.
7. Application must be accompanied by the HIPPA Privacy Authorization Form and copies of the most recent bills requested for payment.
8. Incomplete applications cannot be accepted. All sections must be completed in their entirety.
9. Applications are reviewed as received and, if accepted, will be forwarded bi-weekly to the Client Services Committee for review.
10. The Client Services Coordinator will inform the social worker or referring professional of the applicant's approval status. Bills are paid directly to the creditor, not the client. It is up to the client to supply us with correct and updated information regarding payment addresses and account numbers.

TO SUBMIT APPLICATION:

1. Email completed application with documentation attached to: clientservices.sopf@gmail.com
2. Application must be submitted in its entirety. Incomplete applications will not be accepted.
3. If completely necessary, applications can be mailed to the address below, but please be advised that this can delay the application timeline by 2-3 weeks. **DO NOT FAX. Email is the preferred method for submission**.
4. Upon receipt, applications will be reviewed to ensure that:
    a. Applicant has been diagnosed with breast cancer within 12 months of application
    b. Expenses were incurred after breast cancer diagnosis
    c. Expenses submitted for payment are in applicant's name (or spouse)
    d. Application is filled out in its entirety and includes all necessary documentation
5. Applications reviewed and accepted will be forwarded to the Client Services Committee for consideration and approval.
6. **Questions regarding the status of an application should be directed to the Client Services Coordinator via email at clientservices.sopf@gmail.com.**

Shades of Pink Foundation prohibits discrimination in all its programs and activities on the basis of race, color, national origin, age, disability, marital status, familial status, parental status, religion, sexual orientation, genetic information, political beliefs, reprisal, or because all or part of an individual's income is derived from any public assistance program.

If mailing application, send to:

Shades of Pink Foundation
Attn: Client Services Committee
P.O. Box 2538
Birmingham, MI 48012

Financial Support Request

CONFIDENTIAL

Today's Date:_____

SECTIONS I,II, AND III MUST BE COMPLETED BY NURSE, SOCIAL WORKER, PATIENT NAVIGATOR OR OTHER MEDICAL PROFESSIONAL

I. CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____ Phone _____

City _____, Michigan Zip Code _____

County _____ Email Address _____

II. MEDICAL INFORMATION

Was client diagnosed within last 12 months? ☐ No ☐ Yes Date of Diagnosis:_____

Primary Cancer:_____ Stage:_____

Is client in active treatment? ☐ No ☐ Yes Date treatment began:_____

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Hormonal ☐ Reconstruction ☐ Lymphedema

Has client completed treatment? ☐ No ☐ Yes Date treatment ended:_____

Additional information:_____

_____

_____

III. REFERRAL INFORMATION *(nurse, social worker, patient navigator)*

Name:_____ Title:_____

Institution:_____

Email:_____ Phone:_____

☐ Client has signed HIPPA Privacy Authorization Form granting permission to share the aforementioned medical information with Shades of Pink Foundation for the purposes of this application.

Signature:_____ Date:_____

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IV. HOUSEHOLD FINANCIAL INFORMATION

Employment status at time of diagnosis: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disability
Employment status at time of application: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disability

Number of Adults living in household: _____ *(not including adult children in college or otherwise legal dependents)*
Number of dependents living in household *(minors under 18 or adult children 18-26 who are still in school/college)* _____

Information must be provided for all adult/non-dependents living in household. Please include all sources of income, including payroll/unemployment benefits, SSD/SSI, public assistance, alimony/child support. Adult children attending college do not have to be listed here; however, all other household adults, including roommates, should be listed.

1. ☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ (Source) $_____/month (Amount)
2. ☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ (Source) $_____/month (Amount)
3. ☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ (Source) $_____/month (Amount)
4. ☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ (Source) $_____/month (Amount)
5. ☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ (Source) $_____/month (Amount)

Total Monthly Family Income: $_____ Total Monthly Household Expenses: $_____
Housing Status: ☐ Mortgage – Current ☐ Mortgage – Delinquent ☐ Renting ☐ Living with others ☐ Other_____

Financial Assets: Checking Account/Money Market: $_____ Savings Account: $_____

Please detail how breast cancer as led you to face financial hardship:_____

_____

_____

_____

_____

V. FINANCIAL SUPPORT DETAIL

Shades of Pink Foundation provides temporary financial assistance to women and men who are experiencing financial distress due to breast cancer. Expenses incurred prior to a breast cancer diagnosis are not eligible for assistance. Grants typically cover mortgage/rent, utilities, transportation costs including car insurance, COBRA or health insurance premiums. Medical expenses such as co-pays, prescription costs, deductibles, and medical bills including bills for doctor visits, diagnostic testing, treatment, recovery or reconstruction are not eligible. Credit card bills and student loans are not eligible. Funding is limited and is based on availability and eligibility.

On the next page, please provide detailed information for all bills submitted. All fields must be completed. Supporting documentation must be included with your application, which can include:

- A copy of the most recent bill/statement/invoice
- A copy of the payment coupon for installment loans such as mortgage or car payment
- A copy of the rental agreement if you do not receive a monthly statement from your landlord
- A copy of a legal order with payment terms and instructions.

If you are requesting assistance with more than 5 bills, you can include additional pages.

Please make sure that you provide a copy of the <u>most recent</u> statement, bill, or invoice. Account screen shots from your computer are not eligible unless they show account number, amount owed, billing address, and your name/address.

We cannot process payments without payee information including an account number and mailing address.

BILL STATEMENT SUMMARY

Please complete this form in its entirety. Assistance requests cannot be processed without ALL of the information below as well as a corresponding bill statement for each request. Payments are sent from Shades of Pink Foundation directly to the creditor, not to the client.

Request 1: ☐ **Bill Statement Attached**

Type of Bill:_____ Account #:_____

Amount:_____ Payable to:_____

Address:_____ City:_____ State:_____ Zip:_____

Request 2: ☐ **Bill Statement Attached**

Type of Bill:_____ Account #:_____

Amount:_____ Payable to:_____

Address:_____ City:_____ State:_____ Zip:_____

Request 3: ☐ **Bill Statement Attached**

Type of Bill:_____ Account #:_____

Amount:_____ Payable to:_____

Address:_____ City:_____ State:_____ Zip:_____

Request 4: ☐ **Bill Statement Attached**

Type of Bill:_____ Account #:_____

Amount:_____ Payable to:_____

Address:_____ City:_____ State:_____ Zip:_____

Request 5: ☐ **Bill Statement Attached**

Type of Bill:_____ Account #:_____

Amount:_____ Payable to:_____

Address:_____ City:_____ State:_____ Zip:_____

Please attach an additional page if you have more than 5 requests.

Incomplete applications will not be accepted. Acceptance of your application does not guarantee approval of all bills submitted. The Client Service Committee will review each request to determine eligibility and approval based on available funds. Your social worker will be notified of your application status. Please be advised that it can take 4-6 weeks for payments to process from the date of your application. If your application is not accepted or not approved, your social worker will be notified. Your creditors will be paid directly. Shades of Pink Foundation does not pay financial grants directly to clients.

HIPPA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT, 45 C.F.R. PARTS 160 AND 1647

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described in the Application for Financial Assistance to Shades of Pink Foundation and the Shades of Pink Foundation Client Committee.

2. Effective Period

This authorization for release of information covers the period of health care from

a. ☐ _____ to _____.

****OR****

b. ☐ all past, present, and future periods.

3. Extent of Authorization

I authorize the release of my complete health record as it pertains to my breast cancer diagnosis and treatment, including:

- date of diagnosis
- primary cancer type and stage
- dates of treatment
- types of treatment
- anticipated length of treatment

I authorize the release of financial information as it pertains to my financial hardship due to my breast cancer diagnosis, including:

- employment status
- income sources for ALL household members
- total family income/expenses
- housing status
- family financial assets (bank account balances)
- nature of financial hardship
- documentation of financial support request (copies of bill statements/invoices)

4. This medical and financial information may be used by Shades of Pink Foundation in consideration of the Financial Support Request, which I am submitting through my health care provider as described above.

5. This authorization shall be in force and effect until _____ (date or event) or until I revoke, in writing.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining financial assistance through Shades of Pink Foundation and assistance has already been granted.

7. I understand that my eligibility for financial assistance from Shades of Pink Foundation is contingent on the signing of this release as applications cannot be processed without legal release of medical and financial information.

8. I understand that Shades of Pink Foundation will use the information contained within the Application for Financial Assistance only to determine eligibility for assistance and to collect information regarding payee name and address, account number, and amount due.

9. I understand that the Shades of Pink Foundation provides temporary financial assistance to women who are experiencing distress as a result of breast cancer. Expenses incurred prior to a breast cancer diagnosis will not be covered. Grants do not cover medical expenses such as co-pays, medications, doctor or diagnostic bills. Funding is limited and is based on availability and eligibility.

Signature of patient or personal representative	Date
Printed name of patient or personal representative and relationship to patient	

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