Dear Applicant

Thank you for your interest in Friends In Pink. We understand your feelings and fears because we have been touched by breast cancer, and most of us are survivors. Friends In Pink is a charity that financially assists under-insured and uninsured patients diagnosed with breast cancer. We will do our best to assist you.

Please read the following carefully. You will need to complete all the forms with the exception of the "Letter of Support". The "Letter of Support" **ONLY** needs to be completed if you have no proof of residency. An example of proof of residency is a utility bill (water and sewer, telephone or electricity) showing your name and current address. If you do not have proof of residency, the "Letter of Support" must be completed and notarized. Once the "Letter of Support" is completed and notarized include it in your application package and return the entire package to: Friends In Pink, 774 W Midway Road Fort Pierce, FL 34982.

Please check the "Eligibility Requirements" to make sure you have completed and enclosed all the information in the application. If information is missing or unreadable it could delay our decision making process. PLEASE KEEP A COPY OF THE APPLICATION FOR YOUR RECORDS.

We are here to help you, as much as possible. Should you need help completing the application, or if you have any questions, call me at 772-785-8730.

Once we receive a completed application you will be considered for assistance.

Sincerely,

Bonita Billue

Bonita Billue
Recipient Services

Privacy Authorization Disclosure

(Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164)

1. **Authorization**
   I authorize *Friends In* Pink to **use and disclose my protected health information to all relevant parties, so they may discuss my treatment and financial needs.**

2. **Effective Period - All past, present, and future periods.**

3. **This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment.**

4. **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 insurance coverage and the insurer has a legal right to contest a claim.**

5. **I give permission for my protected health information to be disclosed for purposes of communicating results, and findings to the family members and others listed below:**

Name_____Relationship_____

Name_____Relationship_____

I have received a copy of the Friends In Pink Privacy Authorization Disclosure today.

Applicant/Guardian Signature:_____Date:_____

Eligibility Requirements

Friends In Pink **may provide financial assistance for your breast cancer care. Priority will be given to applicants permanently residing in Martin, Saint Lucie or Indian River County, Florida. Please complete the enclosed application and provide us with the following documents:**

- Completed Privacy Authorization Disclosure form (HIPAA).
- Copy of Florida Driver's License or Florida Identification Card.
- Copy of Social Security Card.
- Copy of Alien Card, Citizenship Certification or Work Permit, if any.
- Copy of Birth Certificate.
- Copy of last paystub from employer, if any.
- Copy of unemployment compensation check stub, in any.
- Copy of **ALL** Vehicle Registrations.
- Copy of Health Insurance Policy, if insured.
- Letter of Support, if appropriate.
- Copy of recent Utility Bill (power, phone, cable or water).
- Copy of the most recent Income Tax Return.

If you should need assistance with providing the above or completing the application, **PLEASE** feel free to contact us at (772)785-8730 and we will be happy to help you though this process.

We are here to help.

Financial Assistance Application

Name _____

Address _____

City **State** **Zip** _____

Phone Number/s **Date of Birth** _____

Circle One:

Social Security Number **Marital Status** (circle one) **Single** **Divorced** **Married** **Widowed** _____

Name of Doctor _____

Doctor's Address _____

Doctor's Phone Number _____

No. of people in Household_____ **No. of children under 18**_____

Race/Ethnicity

Please provide the following information completely and accurately. Information is subject to verification.

Unemployed ☐ **Employed** ☐ **Employer Name** _____

Uninsured ☐ **Insured** ☐ **Insurance Name** _____

Patient/Responsible Party Information:

Monthly Income		***Monthly Expenses***	
Gross Income(before taxes)	$	Rent/Mortgage	$
Other Household Gross Income	$	Property & Health Insurance Expense	$
Investment Income	$	Utilities Expense	$
Rental Property Income	$	Food Expense	$
Unemployment Income	$	Auto Payments (Loan & Insurance)	$
Other Income	$	Medical & Prescription Expense	$
		Other Expenses	$
Total Income	$	**Total Expenses**	$
Assets		***Liabilities***	
Value of Residence	$	Equity Loan	$
Bank Account Balances (ALL)	$	Balance of Mortgage	$
Auto Value	$	Credit Card Debt	$
Boat Value	$	Auto Loan Balance	$
Recreational Vehicle Value	$	Other Loan Balances	$
Other Assets	$	Real Estate Taxes	$
		Estimated Medical Bills	$
		Other Liabilities	$
Total Value Assets	$	**Total of Liabilities**	$

I hereby apply for financial assistance from Friends In Pink. I certify the information provided above is an accurate and a true representation of my financial information. I also certify that I have no additional insurance coverage other than stated above. I understand that providing false information will result in denial of assistance from Friends In Pink. I understand that my credit report will be used to verify this information. My failure to follow through with the application process or take actions to reasonably complete "Patient Eligibility Requirements" may result in denial of this application.

Patient Signature **Date**

Letter of Support

To Whom It May Concern:

I am providing support to _____
(Applicant Name)

In the amount of $_____ per month.

Information from person providing support:

Name: _____
Address: _____
_____
_____
Phone: _____

Signature: _____
Date: _____

Notary Information:

STATE OF FLORIDA
County of _____

Sworn to and subscribed before me this _____ day of _____, 20____, by _____. Who is ____personally known or produced identification _____ type and # of ID_____.

(Stamp)

Notary Public, State of Florida:_____

Commission Expires: _____