Dear Applicant,

Friends In Pink, Inc. is a nonprofit charity that provides financial assistance in the form of a grant, for uninsured and underinsured individuals who have been diagnosed with Breast Cancer. We are a local organization, serving residents of Martin, St. Lucie, and Indian River counties. Friends In Pink, Inc. is operated by Breast Cancer survivors and volunteers. We understand your feelings and fears that is why we are here, to help relieve you of financial worries associated with this devastating illness, so that you may focus on your care and treatment.

Please complete the application included in this packet and carefully read and review the requested eligibility requirements list. Please provide copies of **all** the requested documents with your application, as we cannot process your application without them. A notarized letter of support is needed if you are residing with someone or relying on someone, other than your spouse, for full or partial support. An example of proof of residency is a utility bill, such as electric, water, cable TV, or internet, displaying your name and current address. If you are retired or disabled and no longer file an annual income tax return, you will need to provide a letter of non-filing status in lieu of a tax return. This can be obtained from the Internal Revenue Service, either in person or online.

Please make sure your application is complete and legible, as this will avoid a delay in processing your application and may cause your grant to be denied. Again, **ONLY PROVIDE COPIES OF YOUR PERSONAL DOCUMENTS AND RETAIN A COPY OF YOUR APPLICATION FOR YOUR RECORDS**.

MAIL YOUR COMPLETED APPLICATION TO:
FRIENDS IN PINK, INC.
RECIPIENT SERVICES
1024 NE JENSEN BEACH BLVD
JENSEN BEACH, FL. 34957

We are available to assist you in completing your application. Please feel free to contact us with questions or concerns.

Sincerely,

Oveta J. Trubow
Recipient Services
Friends In Pink, Inc.
772.785.8730
772.245.2772

Privacy Authorization Disclosure

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

1. **Authorization**
   I authorize *Friends In Pink, Inc.* 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, Inc. Privacy Authorization Disclosure today.

Applicant/Guardian Signature: __________________________________Date: _________________

Eligibility Requirements

Friends In Pink, Inc. **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 through 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**_________

Friends In Pink, Inc. |1024 SE Jensen Beach Boulevard| Jensen Beach, FL| 34957 |772-785-8730

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, Inc. 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, Inc. 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: ________________________________