



## Patient Treatment Assistance Guidelines & Requirement

### Applicant Requirements

- **North Carolina resident** who has been diagnosed with breast cancer and is in any phase of active treatment
- Must be a US citizen
- Household income eligibility based on 2018 federal guidelines:

Family Size	Maximum Household Income	Family Size	Maximum Household Income
1	\$30,350	5	\$73,550
2	\$41,150	6	\$84,350
3	\$51,950	7	\$95,150
4	\$62,750	8	\$105,950

### Financial Assistance for Those Who Qualify Includes for Assistance Toward Medical Expenses Associated With:

Surgical Consultations	Surgery (excluding reconstruction)	Chemotherapy Administration (excluding medications)	
Radiation Therapy	Co-Pays and Co-Insurance	Premiums and Deductibles	COBRA Premiums

### Instructions:

- Complete and submit the Financial Assistance Request Form-Preliminary Request by mail or by fax
- Have your referring physician that is providing treatment:
  - Complete the Medical Referral Form
  - Attach your pathology report

The Medical Referral Form must be signed by a referring and treating physician, such as Surgeon, Oncologist, or Radiologist. Your social worker or patient navigator should be able to facilitate getting this form completed, and signed by the doctor. *You can submit the Medical Referral Form and Pathology Report with your Financial Assistance Request Form; Or you can have your physician's office send it directly to us by mail or fax.*

After your Financial Assistance Request is screened and you meet initial eligibility, our Patient Resource Coordinator will contact to make sure all additional documentation is submitted. *If you wish, you may go ahead and submit these documents with your initial Financial Assistance Request. These documents are needed to complete a full application.*

### These will include:

- Last 2 pay stubs or proof of unemployment. If your income is solely Social Security or Social Security Disability Income, then a copy of Social Security or Social Security Disability Income statement or letter.
- Most recent federal tax return (first 2 pages) or Schedule C if self-employed
- Copy of a utility bill
- Your Story
- Medical/Health Information Release & Authorization
- Publicity Release
- Copy of driver's license or alternate ID
- If you are insured: copy of current Insurance, Medicare or Medicaid card (front and back)
- If you are uninsured: copy of Medicaid or social security disability rejection letters, if applicable

### Notes

- Requests cannot be submitted for Medical Advisory Committee review until **all** required documents are received
- Approval may take up to 30 days
- Foundation grants assistance on a first-come, first-served basis to the extent that funding is available
- Medical Advisory Committee sets eligibility criteria and has final determination in all cases and reserves right to change program in its entirety or with respect to any applicant at any time with or without notice



Request received: \_\_\_\_\_

PIPF Number: \_\_\_\_\_

### Pretty In Pink Foundation Financial Assistance Request Form

This preliminary request will be used to determine if applicant qualifies for completion of full application which will be submitted to the Medical Advisory Committee.

**Request may be mailed or faxed to:**

Pretty In Pink Foundation – Attn: Patient Financial Request  
5171 Glenwood Ave- Suite 360  
Raleigh, NC 27612  
Fax: 919-977-6759

**Questions:**

Call: 919-532-0532  
info@prettyinpinkfoundation.org

Applicant Name: _____			Date of Application: _____
(Last)	(First)	(MI)	
DOB _____	Age _____	SSN#(last 4) _____	
Home Address: _____		City: _____	
County: _____	Zip: _____	Email: _____	
Home Phone: _____	Work Phone: _____	Cell: _____	
Referral: Hospital/ Clinic or Patient Navigator: _____		Phone: _____	
Request for assistance: No Medical Insurance / Co-pay / COBRA / Co-insurance / Deductible _____			
Where are you currently in your treatment? Surgery – Chemotherapy – Radiation – Other _____			

**Insurance Information (please check all applicable)**

- 1. Current Coverage: Medicaid \_\_\_ Medicare \_\_\_ Private health insurance \_\_\_ COBRA \_\_\_ Other \_\_\_\_\_
- 2. Insurance Provider: \_\_\_\_\_ Co Pay(s): General \_\_\_\_\_ / Specialty \_\_\_\_\_  
Insurance Monthly Premium \_\_\_\_\_ Deductible \_\_\_\_\_ Deductible Met? Y N

3. Other Financial Assistance/ Charity Programs applied for:

Program \_\_\_\_\_ Outcome \_\_\_\_\_  
Program \_\_\_\_\_ Outcome \_\_\_\_\_

Other assistance requested: Rent / Utilities / Phone /Transportation / Childcare / Food / Wig / Bra / Prosthetic unit(s)

**Medical Information**

Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
Treatment Plan: Surgery \_\_\_\_\_ Chemotherapy \_\_\_\_\_ Radiation Therapy \_\_\_\_\_ Other \_\_\_\_\_

**Financial Services Contacts:**

Name \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax or Email: \_\_\_\_\_

**Physician Care Team:**

Surgeon: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_  
Oncologist: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_  
Radiologist: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_

**Financial Information**

1. Total # in household \_\_\_\_\_ Children under 18 \_\_\_\_\_ Patient Monthly Income \$ \_\_\_\_\_ Spouse Monthly Income \$ \_\_\_\_\_

2. Employed? Y N Last worked: \_\_\_\_\_ PT \_\_\_\_\_ FT \_\_\_\_\_ Casual \_\_\_\_\_

Employer: \_\_\_\_\_

Position/Title: \_\_\_\_\_

If requesting assistance for COBRA: COBRA Monthly payment \_\_\_\_\_ COBRA approval date \_\_\_\_\_

**Income Information**

Income Source	Monthly Amount	Monthly Expense	Monthly Amount
Total Household Income	\$	Rent / Insurance	\$
Unemployment Compensation	\$	Food	\$
Retirement Pension/ SSD/ SSI	\$	Childcare	\$
VA Benefits	\$	Electricity / Heat	\$
Worker's Compensation	\$	Water /Sewer/ Garbage	\$
Interest / Dividends	\$	Cable TV / Internet	\$
Public Assistance	\$	Transportation	\$
Other	\$	Medicine/Supplies	\$
<b>Assets</b>		<b>Liability</b>	
Stocks / Bonds/ Money Markets	\$	Home Mortgage	\$
Rental Income	\$	Property Tax	\$
Family Support	\$	Child Support	\$
IRA / Other	\$	Credit Cards	\$
<b>Total Monthly Income</b>	\$	<b>Total Monthly Expenses</b>	\$

**Release of Information & Authorization**

I have read Pretty In Pink Patient Treatment Assistance Guidelines & Requirements and I declare that the information furnished on this application form is true and correct to the best of my knowledge.

All information is reviewed by members of the Pretty In Pink Foundation Patient Treatment Assistance Medical Advisory Committee and is confidential. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Medical Advisory Committee of Pretty In Pink Foundation.

I understand that any elective procedures (cosmetic surgery/breast implants) are not eligible for financial assistance.

I will apply for assistance (Medicare, Medicaid, and other charity programs), which may be available for payment for my hospital charges. If you receive other assistance, please provide this information to the Pretty In Pink Foundation.

I understand my request for financial assistance may **only** be for eligible expenses (surgery, chemotherapy (less medications), and radiation) as by agreement of participating physician. Requests may also be considered for health insurance premiums and COBRA premiums in situations where coverage is threatened for continuation.

I also understand that if my preliminary application is accepted, I will provide all other items pertaining to request. I understand my submission of full application does not guarantee granting of funding.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date



**Medical Referral**  
**(To be completed by Medical Health Professionals Only)**  
**Fax to Pretty In Pink Foundation: 919-977-6759**

Patient Name: \_\_\_\_\_

Healthcare Professional: \_\_\_\_\_

Name of Practice/Clinic: \_\_\_\_\_

**Please Attach Pathology Report:**

Contact name to discuss financial request: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Diagnosis Code: \_\_\_\_\_

**Current Treatment / Treatment Plan (may attach separate sheet as necessary)**

Surgery \_\_\_\_\_

Chemotherapy \_\_\_\_\_

Radiation Therapy \_\_\_\_\_

Please indicate if others services may be required: \_\_\_\_\_

**Please answer the following to help us review case as presented:**

- Are you a Project Access Enrollee Site? Yes No
- Has patient applied for Medicaid/Medicare? Yes No
- Does your facility or health system offer financial assistance? Yes No
- If yes, has patient completed application? Yes No
- Does patient require additional support services? Yes No
- (Support group, Navigation, accessories (wig, prosthesis, garments, etc) \_\_\_\_\_
- What services are you requesting Pretty In Pink to consider? \_\_\_\_\_

**Other physicians that will be participating in care:**

Surgeon: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_

Oncologist: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_

Radiologist: \_\_\_\_\_ Hospital / Clinic: \_\_\_\_\_

Please write any additional information or comments you may have concerning the applicant receiving financial assistance from Pretty in Pink Foundation and why you are referring this patient.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Name of Referring Physician:** \_\_\_\_\_

**Signature of Referring Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Date Received: \_\_\_\_\_

PIPF Number: \_\_\_\_\_

**MEDICAL/HEALTH INFORMATION RELEASE & AUTHORIZATION**

North Carolina and Federal law protect the privacy and confidentiality of an individual patient’s medical records. In order for Pretty In Pink Foundation to access your medical information as part of its financial assistance process, a Release & Authorization form must be executed for your health care provider(s).

I authorize Pretty In Pink Foundation to request, use, and disclose certain health care and billing information regarding my breast cancer diagnosis, treatment, and medical bills from and to the following:

\_\_\_\_\_  
(Name of health care provider)

\_\_\_\_\_  
(Name of health care provider)

\_\_\_\_\_  
(Name of health care provider)

Information will be used or disclosed for the following purposes: to assist the Foundation in determining my eligibility for financial assistance, and if awarded assistance to pay grant funds toward eligible medical bills. Pretty In Pink Foundation will not receive payment or other remuneration from a third party in exchange for using or disclosing health information, and will maintain privacy regarding personal health information.

This Release and Authorization shall expire twelve (12) months from its execution, if not revoked prior thereto. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Pretty In Pink Foundation at 5171 Glenwood Ave, Suite 360, Raleigh NC, 27612 or emailed to [info@prettyinpinkfoundation.org](mailto:info@prettyinpinkfoundation.org).

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
SSN (last 4 digits only)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date





## Publicity Release of Information

Pretty In Pink Foundation asks for your permission to share your story with others to help raise public awareness of the Foundation, communicate to donors and the community to support the cause, and inform breast cancer patients, healthcare providers, and others about the Foundation's services.

Yes, I allow Pretty In Pink Foundation to use my first name, photo, quotes, all or part of my story, demographics, and information about my diagnosis, medical care, and the services received from the Foundation. The information will be used in public publications and general media, which include but are not limited to digital and print publications, fundraising materials, presentations, testimonial stories highlighting services, and website and social media.

No, I do not give permission for Pretty In Pink Foundation to use my personal information or images in publications, general media or materials.

I understand that my approval or denial of permission will in no way affect the assistance provided to me by the Foundation.

I understand that information disclosed may be subject to redisclosure and may no longer be protected by Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act.

I understand that Pretty In Pink Foundation owns all marketing and outreach materials as released by me, and I hereby release rights to these items. I understand I will not be compensated for the use of the released information. I have read and understand the terms of this release. I certify that I am of legal age, 18 years of age or older.

I understand I have the right to revoke my authorization at any time by writing to by contacting Pretty In Pink Foundation at [info@prettyinpinkfoundation.org](mailto:info@prettyinpinkfoundation.org) or at the below address. Revocation will be effective upon receipt and affects disclosure moving forward and is not retroactive.

Name (printed): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

### Please Mail or Email the Completed Form To:

Pretty In Pink Foundation  
5171 Glenwood Avenue, Suite 360  
Raleigh, NC 27612  
Email [info@prettyinpinkfoundation.org](mailto:info@prettyinpinkfoundation.org)