Linked By Pink, P.O. Box 8177, Erie, PA 16505 814-969-5957
Email: info@linkedbypink.org Web: www.linkedbypink.org

LINKED BY PINK MEDICAL GRANT

* The age limit has been temporarily increased to those diagnosed before the age of 55

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

FINANCIAL ASSISTANCE OPTIONS (Check all that apply):

I am applying for the following grant(s):

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

PATIENT INFORMATION (please print)

Today's date: _____

First name: _____ Last name: _____

Address: _____ City, State, Zip: _____

Phone number: Home ( ) _____ Work ( ) _____

Cell ( ) _____ Email Address _____

Date of birth: _____

MEDICAL INFORMATION (Must be completed by nurse, doctor, or social worker ONLY.)

Date of 1st diagnosis: _____ Age at 1st 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

***Please Note: Hormonal Therapy is NOT considered active treatment**

If not in active treatment, indicate frequency of follow-up: ❑Yearly ❑Every six months ❑Other_____

Please indicate type of treatment(s) received in past twelve months (check all that apply)

❑Chemotherapy ❑Radiation ❑Surgery ❑Hormonal ❑Palliative care ❑Bone marrow/stem cell transplant ❑Physical therapy

HEALTH CARE PROFESSIONAL INFORMATION (please print):

MD name: _____ 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

Your relationship to person applying for help: ❑Doctor ❑Nurse ❑Social Worker ❑ACS Patient Navigator

Signature of MEDICAL PROFESSIONAL: _____ **Date:** _____

Linked By Pink, P.O. Box 8177, Erie, PA 16505 814-969-5957
Email: info@linkedbypink.org Web: www.linkedbypink.org

*** Form must be signed by health care provider in order to be considered.**

THIS PAGE 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 provider? _____

Are you choosing to go out of network for services? ❑Yes ❑No

Are prescription drugs covered? ❑Yes ❑No

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)**

Please be aware that funds are limited and based on availability.

Patients must also meet Linked By Pink's eligibility requirements.

All information is strictly confidential and is for Linked By Pink use only.

Linked By Pink, P.O. Box 8177, Erie, PA 16505 814-969-5957
Email: info@linkedbypink.org Web: www.linkedbypink.org

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_____ Kwik Fill_____

*If choosing Living Expense Grant

Please specify if you would like: Grocery card ____ or Rent/Mortgage/Utility Assistance _____

*For Grocery Card please check where you would like it from: Giant Eagle _____ Wegmans _____ Aldi's _____

*For Rent/Mortgage/Utility option we will need a copy of the lease/mortgage/utility payment coupon showing patient 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.**