PINK HEALS LAKE COUNTRY, INC

Financial Assistance Program Guidelines
501(c)(3) Public Charitable Organization

Financial Assistance Program Purpose

The program is made available to provide direct financial support for cancer patients that currently reside in our area and are in active (or have recently completed) treatment for cancer so that the focus can be on healing.

Summary

Financial assistance is available to men, women and children diagnosed with cancer who reside in Waukesha County. If funds remain at the end of each month, we will open our funding to our bordering counties. The applicant must be currently undergoing active treatment for cancer. This program is available due to the generosity of our donors and the volunteers that assist with our fundraising events. We believe that the money raised in our communities should remain local to support people in our community.

Policy

The policy for the Financial Assistance Program exists to guide PINK HEALS LAKE COUNTRY and volunteers in processing requests from cancer patients who have applied for financial assistance.

1. The Financial Assistance Program has the right to have "open and closed" periods due to fund availability.
2. The Financial Assistance Program will assist as many applicants as funds permit. The committee reserves the right to distribute assistance amounts based on funds available.
3. Each applicant may apply once per year, up to two (2) years total.
4. Financial assistance will be determined on a per applicant basis.
5. Financial assistance is provided directly to the creditor.

Application Process

1. The applicant requesting assistance will complete the application and mail it to PINK HEALS LAKE COUNTRY, ATTN: Financial Assistance Program, PO Box 180402, Delafield, WI 53018.
2. Once a complete application is received, a member of the Pink Heals Lake Country board of directors will Review the application and contact the applicant by telephone. Applications are reviewed once a month.
3. Upon completion of the interview, the board of directors will determine the applicant's eligibility for financial assistance, the amount of financial assistance and to whom the assistance will be paid.
4. Once the board of directors has made its determination, the applicant will be notified via letter and the Determined assistance amount will be paid to the patient's creditor upon receipt of requested documentation.
5. If no creditor documentation is received within 60 days of the approval letter, the application will be closed and available funds will revert back to the Financial Assistance Program for disbursement.

Disclosures

1. Pink Heals Lake Country, Inc has the right to make changes to the application process at any time.
2. **If you are with a doctor's office or a social worker with questions about our program, please contact us before having patients apply**. We can be reached via email at pinkhealslc@gmail.com and please include a phone number that we may contact you directly.

PINK HEALS LAKE COUNTRY
Application for Financial Assistance
CONFIDENTIAL

To be considered for financial assistance, the patient must reside in Wisconsin, with preference given to Waukesha County residents. Please make sure that all sections of this application are complete and have original signatures. Send the completed and signed application to:

PINK HEALS LAKE COUNTRY
Financial Assistance Program
PO Box 350
Hartland, WI 53029

This section to be completed by a health professional at your treatment facility

Patient's Name: _____

Date of Diagnosis: _____ **Primary Cancer:** _____**Current Stage:** _____

Is the patient above currently under the care of your facility for cancer treatment? _____ Yes _____ No

<u>Current Treatment (check all that apply)</u>

_____ Surgery _____ Chemotherapy _____ Radiation _____ Hospice/Palliative Care

Frequency of Treatment: _____

Physician Name: _____

Clinic/Hospital Name: _____

Address: _____ **City:** _____ **Zip:** _____

Person completing this form if different than patient: _____

Relationship to patient: _____Physician _____ Nurse _____ Social Worker _____ Other_____

Phone number: _____ **E-mail address:** _____

Signature: _____ **Date:** _____

Describe this patient's need for assistance: _____

Personal Information

First Name: _____ **Last Name:** _____

Address: _____ **City:** _____ **Zip:** _____

Daytime Phone: (_____) _____-_____ **E-Mail Address:** _____

Date of Birth: _____/_____/_____ (If patient is under 18, provide name of parents/guardians below)

Parent/Guardian Names:
_____

Marital Status: _____ Single _____ Married _____ Divorced _____Widowed

How did you hear about Pink Heals Lake Country?

_____

Financial Information

Patient's Employment Status: _____ Employed _____ Unemployed _____ Retired _____ Disability _____

_____ Student

Number of persons living in household: _____ Household's Total Annual Income: $_____

Age of household residents: _____

Proof of Income MUST be provided with this application

(Social Security number may be omitted)

Request for Assistance

Type of assistance being requested: (check all that apply)

____ **Transportation** **_____Groceries** **_____Utilities** **(**Current bill or statement must be included)

____**Rent Assistance** (Must include statement from Landlord)

____**Medical bill Assistance** (must include verifiable bill or statement from physician or clinic/hospital}

____**Other** Please describe _____

Health Insurance Information

Do you have health Insurance? ___No ___ Yes If yes, type of insurance (check all that apply)

____ Health insurance through employer or purchase privately

____Medicaid ____Medicare _____ Wisconsin Well Women Coverage _____ Badger Care

____ Other _____

Have you applied for funding from any other public or private foundation? _____ No _____ Yes

If yes, please provide name of foundation, date received and amount received.

_____

_____Please check here if you have previously received assistance from Pink Heals Lake Country.

ADDITIONAL INFORMATION FOR REQUESTING FINANCIAL AID

Use this space to add any comments explaining why you are requesting financial aid from Pink Heals Lake Country. These comments might be helpful when reviewing your application.

_____

_____

I certify that all information contained in this application is correct and complete to the best of my knowledge. I understand that submission of this application does not guarantee funding. I understand that Pink Heals Lake Country will not make monetary payments directly to individuals. If funding is awarded, fund will go directly to the vendor of goods/services provided.

Applicant's signature: _____ Date: _____

I authorize a representative from Pink Heals Lake Country, WI to verify with my physician that I am in treatment for cancer.

Applicant's signature: _____ Date: _____

---------- **For Pink Heals Use Only** ----------

Date _____ _____ Approved _____ Denied

Type of assistance: _____ Amount: _____

Comments: _____