Pink Assistance Fund (PAF) Program

LOUDOUN BREAST HEALTH NETWORK

Awareness, education, support ...and life.

For Loudoun County Breast Cancer Patients

Sponsored by:

The Loudoun Breast Health Network

PAF Program Mission Statement: The Pink Assistance Fund was established in October of 2011 by the Loudoun Breast Health Network to assist the residents of Loudoun County with financial assistance incurred during diagnosis and/or treatment (within 12 months of request) for breast health issues.

(26 October 2011)

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Application Guidelines

4 Easy Steps:

STEP 1. Complete ALL sections of: The Pink Assistance Fund (PAF) Program Application (page 5)

STEP 2. Attach the following required documents to the application:

a. Copy of driver's license
b. Physician's verification (page 7)
c. Verification of monthly house payment/rent, i.e., copy of cancelled check
d. Copy of most recent utility bill
e. Copy of pay stub for last month (applicant & spouse)
f. Copy of medical insurance card (if applicable)

STEP 3. Fill out and sign the Release & Authorization Form (page 6)

STEP 4. Send in the PAF Program Application, Required Documents (listed above) and the Release & Authorization Form to:

LBHN/PAF Program
PO Box 6154
Leesburg, VA 20178

Once your application has been received, LBHN will contact you within 7-10 days to set up a personal interview.

If you are unable to obtain the documents requested or have any questions regarding the application process, please contact LBHN at info@lbhn.org.

Application Guidelines
(Continued)

The amount/type of financial assistance provided to patients is determined by funds available and is on a case by case basis.

Types of assistance available:

- Medical - insurance co-pays, prescriptions, medical procedures/treatments
- Travel - gas cards, car payments
- Personal Care - prostheses, wigs, bras
- Utilities - gas, electric, water
- Food - grocery cards
- Housing - assistance with rent/mortgage payment
- Other items as needed

Loudoun Breast Health Network (LBHN) is committed to a policy of equal opportunity/affirmative action for all qualified persons and does not discriminate on the basis of race, color, national origin, sex, disability, age, religion or other basis prohibited by state and federal non-discrimination laws.

Important NOTE: LBHN will verify all information listed on the application form.

Pink Assistance Fund (PAF) Program Application

Full Name: _____

Date of Birth: _____

Address: _____

_____

_____

Email: _____

Home Phone: _____

Cell Phone: _____

List all dependents and ages:

_____

_____

Insurance company & phone number:

_____

Policy number: _____

Monthly Income before diagnosis: _____

Source of Income: _____

Monthly Income after diagnosis: _____

Source of Income: _____

Date of Diagnosis: _____

Physician Name: _____

Physician Address:

_____

_____

Physician Phone Number:

_____

Treatment Plan:

_____

_____

Type of Assistance Needed (Check all that applies):

- Medical - insurance co-pays, prescriptions, medical procedures/treatments _____
- Travel – gas cards, car payments _____
- Personal Care – prostheses, wigs, bras _____
- Utilities - gas, electric, water _____
- Food – grocery cards _____
- Housing - assistance with rent/mortgage payment _____
- Other items as needed (list) _____
- Approximate Dollar Amount of Assistance Requested: $ _____
- Other Considerations/Notes (list on back):

Release & Authorization Form

I hereby authorize any person or company I have listed as a reference on my application to disclose in good faith any information they may have regarding my qualifications for financial assistance with Loudoun Breast Health Network's Pink Assistance Fund (PAF) Program. I agree to hold harmless and indemnify, LBHN's PAF Program and all persons giving references about my application, from liability for any claims whatsoever and of any kind, arising from the exchange of this information.

Signed: _____ Date: _____

Printed Name: _____

Photo/Story Release (sign and date only one)

I understand that public relations are essential for LBHN's PAF Program to obtain donations and funding in order to financially assist breast cancer patients. On behalf of my heirs, my personal representatives, executors and me, I allow LBHN's PAF Program the right to use my story and any photos they take of me for use in public relations efforts.

Also, all photographs that I submit will become the property of LBHN's PAF Program with the rights to the photographs.

Signed: _____ Dated: _____

Printed Name: _____

OR

I do not authorize LBHN's PAF Program to share my story or to use any photographs taken or provided to them in any manner.

Signed: _____ Dated: _____

Printed Name: _____

Physician's Verification Form

Please ask your physician to complete the information in the box below.

To Be Completed by Patient's Doctor	
Name of Patient:	
Patient Diagnosis:	**Date of Diagnosis:**
Is Patient In Active Treatment:	☐ **Yes** ☐ **No**
When Did/Will Treatments End?	
Provider Name:	**Hospital/Clinic:**
Address:	**City/State/Zip:**
Phone:	
Provider Signature:	**Date:**
Additional Comments:	