LOUDOUN BREAST HEALTH NETWORK

Awareness, education, support… and life

Pink Assistance Fund (PAF) Application

For Loudoun County Breast Cancer Patients

STEP 1: Complete ALL sections of: Pink Assistance Fund (PAF) Application (page 2)

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

a. Copy of driver's license *or* proof of residence (i.e. utility bill in your name listing address)
b. Physician's verification form (page 4)
c. Attach copies of all bills you would like considered for payment (i.e. medical, mortgage statement, rental agreement, car loan, insurance premiums, etc.)

STEP 3: Complete and sign the Release & Authorization Form (page 3)

STEP 4: Have your physician's office complete and sign Physician's Verification Form (page 4)

STEP 5: Mail everything from Steps 1-4 (PAF Application, Required Documents listed in Step 2, Release & Authorization Form and Physician Verification Form) to:

LBHN/PAF Program
P.O. 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 email LBHN at pafinfo@lbhn.org. Note: failure to provide the needed documentation will result in a longer processing time.

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

Pink Assistance Fund (PAF) Application

Full Name:

Date of Birth:

Address:

Email:

Home Phone:

Cell Phone:

How did you hear about us:

List all dependents and ages:

Date of Diagnosis:

Physician Name:

Physician Address:

Physician Phone Number:

Treatment Plan:

Type of Assistance Needed (**List all that applies and Amounts**):

- Medical – bills, co-pays, insurance premiums, prescriptions and medical procedures/treatments _____
- Transportation – car payments, car insurance, gas cards _____
- Utilities - gas, electric, water _____
- Food – grocery cards _____
- Housing - assistance with rent/mortgage payment _____
- Personal Care – prostheses, wigs, bras _____
- Other items to consider for assistance (list) _____
  _____

Approximate Total Dollar Amount of Assistance Requested: $_____

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

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: _____ Dated: _____

Printed Name: _____

Story Release (Sign and date only ONE)

- I understand that sharing stories are essential for LBHN's PAF Program to obtain funding to assist breast cancer patients financially. On behalf of my heirs, my personal representatives, executors and me, I allow LBHN's PAF Program the right to use my story for use in public relations efforts. **PLEASE NOTE:** you will remain **ANONYMOUS**.

Signed: _____ Dated: _____

Printed Name: _____

OR

- I do not authorize LBHN's PAF Program to share my story.

Signed: _____ Dated: _____

Printed Name: _____

Physician's Verification Form

Please ask your physician to complete the information and sign the form 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:	