For Office Use: Date Received: ________________________

PRF # ________________

Breast Cancer Grant Application

If you have BREAST CANCER, in order to receive assistance you must live in or receive treatment in, one of the following counties: **Covington, Forrest, George, Greene, Jasper, Jones, Jeff Davis, Lamar, Lawrence, Marion, Pearl River, Perry, Simpson, Smith, Stone, Walthall, and Wayne.**
Mail this Form with copies of bills for which you are requesting assistance:

The Pink Ribbon Fund

5891 US Hwy 49 S677
#60-210
Hattiesburg, MS 39402

Payments will be made directly to the provider of products or services on behalf of the applicant.

Submitting this application does not guarantee funding approval.
Please **PRINT CLEARLY** and **COMPLETE BOTH SIDES** of this form.

Name: ____ Social Security #: ______________________

Date of Birth: ________________ Date of Breast Cancer Diagnosis: __________________________

Address: ____

City: _________________________ County: ___________________ Zip Code: _________________

Email: _______________________________________ Phone: ________________________________

Alternate Phone or Cell: _________________________

Health Insurance: Yes____ No____ **Medicaid**: Yes ____ No ____ **Medicare**: Yes ___ No ____

Type of Assistance Requested: Check all that apply

(Please include with this application copies of bills, which must be related to breast cancer)

_____ Hospital Bills _____ Doctor Bills _____ Lab Bills _____ Radiology Bills _____ Pharmacy Bills

_____ Insurance Deductibles - $1,000.00 Maximum per patient. ***(Include copy of bill. Checks will be made to the Medical provider)***

_____ Diagnostic mammogram, needle biopsy, PET scan **(Not for routine annual exam)**

_____ Breast Prostheses (Every 2 years)

_____ Bras (3 per year)

_____ Wig ______ Hats _____ Scarves _____Cancer I.D. Bracelet

_____ Transportation Assistance to Medical Visits **(Only for patients in active treatment)**

_____ Lymphedema Sleeves **(Must send copy of Dr.'s prescription)**

_____ Gloves **(Must send copy of Dr.'s prescription)**

_____ Physical Therapy Related to Lymphedema **(Must send copy of Dr.'s prescription)**

_____ Would you be interested in receiving information about a Free Exercise Program?

THE PINK RIBBON FUND DOES NOT PROVIDE FUNDING FOR HOUSEHOLD EXPENSES

Please give details about the help you are seeking so we may have a more complete picture of your situation. You may attach an additional sheet, if necessary.

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DOCTOR VERIFICATION STATEMENT:

The person identified in this application has been or is being evaluated for breast cancer.

Doctor's Name: ____ **(Please Print)**

Doctor's Signature: ______________________________ **Date:** ______________

Applicant Verification and HIPAA Permission Statement

I swear that the information on this form is true and accurate.

I hereby authorize *The Pink Ribbon Fund Grant Committee* to contact my doctors and other healthcare providers for health and financial information related to my breast cancer in order to help me with my medical bills. I understand that I have the right to revoke this authorization at any time, and that I must do so in writing and present the written revocation to *The Pink Ribbon Fund Grant Committee*. I understand that the revocation will not apply to information already released by this authorization. I have read the above, and authorize the disclosure of the protected information as stated above.

This authorization is designed to comply with the Health Insurance Portability and Accountability Act, and the regulations promulgated thereunder, 45 CFR parts 160 and 164 (collectively known as "HIPAA.")
A photocopy of this authorization shall be considered as valid as the original, and this authorization will remain in effect two (2) years after the date of the signature above.

Applicant Signature: ______________________________ **Date:** ______________

How/where did you get this application? ____________________________________

Questions: 601-450-4392 **Fax Us at: 601-582-5461**

Funds for this grant are provided by our annual fundraisers and by donations from many generous sponsors, corporations, groups, and individuals.

A Unit of Southeast Mississippi Rural Health Initiative, Inc.
Equal Opportunity Service Provider

REVISED 10/06/2020