C. WRIGHT PINK RIBBON PROJECT

AWARENESS EDUCATION SUPPORT

STOP BREAST CANCER

APPLICATION

Let us therefore come bodly unto the throne of grace, that we may obtain mercy, and find grace to help in time of need. Hebrews 4:16

SECTION 1. APPLICANT INFORMATION

Name: _____ Date of Birth _____

Sex: Male _____ Female_____ Marital Status: _____

Spouse's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Number _____Email: _____

Children/Ages: _____

Religion: _____ Church Affiliation: _____

Date of Diagnosis:_____ Stage: _____ Metastatic disease: _____

Doctor: _____ Treatment: _____

Surgery: _____Estimated length of treatment _____

Please include a signed letter from your oncologist (on letterhead) verifying your current diagnosis and treatment plan, or a letter (on letterhead) from a licensed social worker or case worker verifying your current diagnosis and treatment plan.

SECTION 2. FINANCIAL INFORMATION

Please include a copy of your driver's license or valid state ID card and your most recent paystub in order to process application

Employment: _____ Length of employment: _____

Address: _____City: _____State: _____

Family Income: _____ List all Household Members/Ages: _____

_____

Monthly Income: _____ Health Insurance:_____

Other sources of income/Amount: Include SSI, Pension, Child Support, Unemployment

_____

Monthly Expenses:

Rent/Mortgage: _____ Health Insurance: _____

Gas: _____ Water:_____

Electric: _____ Medical Expenses: _____

Car Payment: _____ Child Care: _____

Telephone:_____ Other: _____

Please include a copy of all bills you wish considered for payment.

Have you previously applied for, or received any type of assistance payments, benefits or Food Stamps in Louisiana or another state in the past year?
If yes, When? _____ Type? _____ Amount? _____

Since your diagnosis have you received assistance from any other community agencies? If so please list the agencies and amount of assistance: _____

Who referred you to C. Wright Pink Ribbon Foundation? _____

Please briefly describe the assistance you are seeking from C. Wright Pink Ribbon Foundation:

The C. Wright Pink Ribbon Project provides direct payments of bills to any individual diagnosed with breast cancer and undergoing **active treatment** or in the immediate **recovery period**. **Active treatment** is defined as the period after diagnosis of breast cancer has been made, and a surgical procedure has taken place. Surgical procedure is defined as a single or bi-lateral mastectomy, lumpectomy, axillary dissection or sentinel node biopsy, or you are currently undergoing chemotherapy, or radiation. **Recovery** is defined as a set period of time determined by your physician, but not exceeding 90 days after completion of treatment or surgery. Any assistance is subject to available funding and to individuals who have demonstrated a financial need. Maximum time aid can be received by any one individual is once every 12 calendar months. The CWPRP reserves the right to decline any applicant for incomplete information, inconsistent or questionable information, lack of funds or other reasons determined by the CWPRP.

Note: Please do not include original copies of bills.

You may fax the completed application to 318.742.0871, or email to cwrightproject@yahoo.com. Any questions please call us at 318.453.3544

Applicant Signature: _____Date:_____

For office use only:

Screener's Name:_____ Date Screened: _____

Disposition:_____