POWER of PINK!
FOUNDATION

CRITERIA FOR FINANCIAL ASSISTANCE

POP!'s mission is to empower a lifestyle of emotional, physical, and financial wellness that strengthens the lives of breast cancer survivors of color.

Requests for Assistance from individuals living in the Washington DC-Metropolitan area are given priority; however individuals outside of this area may apply.

1. Assistance may be sought for the Bag of Hope program (i.e. groceries, house cleaning, and gas cards) only. A letter of explanation documenting why you are seeking assistance must be included with application. We do not accept requests for payment of phone bills.

2. Individuals requesting assistance must be receiving chemotherapy and/or radiation treatment at the time of request and such treatment must be within 120 days of breast cancer surgery. Requests beyond 120 days of breast cancer surgery but less than one year must include an explanation of why treatment was delayed. Individuals receiving any other type of treatment related to their breast cancer diagnosis do not meet guidelines for assistance.

3. Omission of any item listed below will cause your application to be considered incomplete.
    a. A fully completed application with requested supporting documentation,
    b. A properly executed medical confirmation letter from your physician and/or oncology radiologist currently overseeing your chemotherapy and/or radiation treatments only; and
    c. A short letter explaining why you are seeking assistance which should also include any explanation to any question in the application.

4. Approval of your request is based solely on the information provided. You will not be contacted regarding further information or an explanation. Every effort will be made to provide a response to all qualified requests within three business days upon receipt of request. If we are unable to service you at the time your application is submitted, you will be put on a waitlist and notified immediately as funds become available.

5. All documentation must be included for request to be considered. **YOU MUST COMPLETE ALL FIELDS.**

Application for Assistance

INSTRUCTIONS: Please read the entire application form including the attached "Criteria for Financial Assistance". Print your answers clearly.

MAIL TO:
P.O.P.! Power of Pink! Foundation, Inc.
6368 Coventry Way, #347
Clinton, Maryland 20735
240.389.4POP (4767)
www.powerofpinkfoundation.org

For speedier service: Email the application and related documents to **info@powerofpinkfoundation.org**

This becomes a valid application once you enter your name and address, and signed the form. You may have someone other than a P.O.P.! staff member help you complete this form for you or on your behalf. Determinations of approval or denial are based solely on the information provided. If you need additional space, attach a separate sheet of paper and identify which question(s) you are answering. Requests are on a first come, first serve basis, while supplies last. The amount of assistance is determined on a case-by-case basis but no approved request will exceed $500 per individual. Approval is not guaranteed and amount of assistance will be based on our available funding levels.

Complete all sections of the application.

PART I: APPLICANT INFORMATION (Please Print Clearly)

Date: ________________________________
Last Name: ___________________________ First Name: __________________________________
Address: _____________________________ City/State/Zip: _______________________________
Home Phone: ( ) ___________________ Work: ( ) _________________________________
Date of Birth: ________________________ Age: ___________ ☐ Male ☐ Female
Ethnicity: ________________________ [**OPTIONAL** - Indicate the race. Title VI of the Civil Rights Act of 1964 allows us to ask for this information. This information will not be used in determining eligibility for assistance. If you do not provide this information, it will not affect your application. We ask for the information to assure that benefits are distributed without regard to race, color or national origin.]

If patient is a minor, name of parent or guardian: ____

PART 2: FINANCIAL INFORMATION – MUST COMPLETE THIS SECTION

Estimated Monthly Utility Expenses			Family Assets	
Phone	$		Checking	$
Oil/Gas	$		Savings	$
Electric	$		Money Market	$
Water	$		Other	$
Total	$		**Total**	$

Are you currently employed: ☐ Yes ☐ No Number in household: Adults_____ /Children_____

How did you hear about us? ____

Who else have you applied to for assistance? ____

Were you approved? □ Yes □ No

Household Income Sources: (Please check all that apply):
Please send evidence of income (REQUIRED)

Social Security		Public Assistance		Unemployment	
Pension		Child Support		Short Term Disability	
SSD (Disability)		Sick Leave		Family/Friends support	
Alimony		Salary		Other – Specify:	

No income at this time ☐

Total Amount Received: $_____________ Monthly $_____________ Weekly $______________

TOTAL Monthly Family Income: $ _________________

PART 3: ASSISTANCE YOU ARE SEEKING? (May select up to 3)

☐ Groceries ☐ Gas Card □ Metro Subsidy ☐ Toiletries ☐ Cleaning Program *(currently MD residents only)*

On a separate sheet of paper please provide a brief explanation as to why you are requesting assistance from POP!'s Bags of Hope Program. (**Required**)

Have you previously requested assistance from P.O.P.! before: ☐ Yes ☐ No

If Yes, please indicate month and year of assistance: __________________________ (mm/yyyy)

Signature of Applicant: ____

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FOR OFFICE USE ONLY

After careful consideration the Board of Directors of POP!, Inc. has approved this request to provide assistance for the following:

Requestor Name: ____

Grocery Card: ____ **Amount: $ _________________**

Gas Card: _____________________ **Metro Card**: □ **Amount: $ _________________**

Cleaning Program: _______________________________________ **Date of Service: ____________**

Approved by (*two signatures required*):

Name: ______________________________ Title: ___________________ Date: __________

Name: ______________________________ Title: ___________________ Date: __________

Action	Date	By
Request Received – Application		
Medical Confirmation Letter Received		
Grocery Card to Client		
Gas/Metro Card to Client		
Cleaning Program Started		
Copy of Payment & Letter Sent to Applicant		
Letter of Denial to Applicant		

LETTER CONFIRMING MEDICAL TREATMENT OF BREAST CANCER DIAGNOSIS
(Please have this letter completed by your physician)

Date: ___________________________

Name of Patient: ____

Dear Sir/Madam:

This letter confirms that the above-referenced patient has been diagnosed with breast cancer and is currently receiving treatment for same. Relevant information pertaining to the above-reference patient is as follows:

Date of Diagnosis: ____

Date of Surgery: ____

Date Patient returned to work: ____

Date of Radiation treatments: ___________________________ to ___________________________________

Date Chemotherapy treatment began/will begin: ____

Duration of Chemotherapy treatment: ____

Sincerely,

____
Physician Signature

PLEASE PRINT CLEARLY

Physician: ____

Address: ____

____

Phone: ____ Fax: _______________________________________

Email: ____

Please mail this letter to the address above or email to info@powerofpinkfoundation.org. Request for the POP! Bag of Hope program cannot be processed without receipt of this letter properly completed. Thank you.