



All Shades of Pink

Helping Families Fight Breast Cancer

Rev. 03-2010-1
P.O. Box 501
Glenn Dale, MD 20769
Phone: 301-356-4688
Fax: 1-866-800-0303
Email: asop@allshadesofpink.org
Website: www.allshadesofpink.org

Application for Emergency Financial Assistance

INSTRUCTIONS: Please read the entire application form including the attached "Criteria For Financial Assistance". Print your answers clearly. **MAIL TO:** ALL SHADES OF PINK, P.O. BOX 501, Glenn Dale, MD 20769. You may also fax the application and related documents to 1-866-800-0303.

This becomes a valid application once you enter your name and address, and signed the form. You may have someone help you complete this form for you or on your behalf. We may have to contact you in order to process your application. If you need additional space, attach a separate sheet of paper and identify which question(s) you are answering. Assistance may be provided up to 3 consecutive months, but not to exceed \$750 in a 12 month period.

Requestor Information (Please Print)

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: _____

For ASOP Use Only: ASOP # _____

Financial Information

<u>Estimated Monthly Utility Expenses</u>	<u>Family Assets</u>
Phone: _____	Checking: _____
Gas: _____	Savings: _____
Electric: _____	Money Market: _____
Oil: _____	Other: _____
Total: _____	Total: _____

TOTAL Monthly Family Income: _____

Are you currently employed: Yes No

Number in household: Adults ___ Children ___

Income Source: (Please check all that apply):

<input type="checkbox"/> Social Security	<input type="checkbox"/> Alimony	<input type="checkbox"/> Salary
<input type="checkbox"/> Pension	<input type="checkbox"/> Public Assistance	<input type="checkbox"/> Short Term Disability
<input type="checkbox"/> SSD (Disability)	<input type="checkbox"/> Child Support	<input type="checkbox"/> Family/Friends provide support
<input type="checkbox"/> Other – Specify: _____	<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSI
	<input type="checkbox"/> Sick Leave	

WHAT KIND OF UTILITY ASSISTANCE ARE YOU REQUESTING? Check all that apply:

Land Line Phone Electric Gas Oil
 Other Utility (please specify) _____

On a separate sheet of paper please provide a brief explanation as to why you are requesting assistance from All Shades of Pink’s Emergency Assistance Fund. (Required)

Have you previously requested assistance from ASOP before: Yes No
If Yes, please indicated month and year of assistance: _____ (mm/yyyy)

Have you received a Cut-off or Suspension Notice: Yes No
If yes, please provide a copy of your Cut-off or Suspension Notice. Please note that address on notice must be the same as your home address provided on application.

Who is the specific creditor/provider of service the funds would be paid to: Name of Creditor/Service Provider: _____ Address of Creditor/Service Provider: _____ _____ Amount of Bill: \$ _____ Your Account/Billing Number: _____ If late, please give a brief explanation:
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FOR OFFICE USE ONLY

After careful consideration the Review Board of All Shades Of Pink, Incorporated has unanimously approved to provide emergency financial assistance for the following:

Requestor Name: _____

Creditor/Service Provider Name	Account #	Check No. & Date	Amount
			\$
			\$
			\$

Approved by (*two officer signatures required*):

Name: _____ Title: _____ Date: _____

Name: _____ Title: _____ Date: _____

Action	Date	By
Request Received – Application <input type="checkbox"/>		
Copy(ies) of Cut-off or Suspension Notice Received <input type="checkbox"/>		
Medical Confirmation Letter Received <input type="checkbox"/>		
Payment to Creditor/Service Provider		
Copy of Payment & Letter Sent to Requestor		
Letter of Denial to Requestor		



All Shades of Pink

Helping Families Fight Breast Cancer

CRITERIA FOR FINANCIAL ASSISTANCE

1. All Shades of Pink's mission is to help breast cancer families in need of financial assistance regarding payment of utility services when such services are about to be suspended, cut-off or terminated. Bills that are delinquent in payment are not eligible. **Documentation must state clearly that services are in jeopardy of disruption and the date when such services will be disrupted.**
2. ***At this time, assistance is limited to individuals living in Prince George's County and the Washington Metro area.***
3. Assistance may be sought for utility services (i.e. electric, gas, phone, insurance) and in some cases other related expenses such as transportation, food and medicine as determined by the Review Board. However, we request a letter of explanation for requests other than utility assistance as outlined in item 1 above.
4. Individuals requesting assistance must be receiving **chemotherapy and/or radiation treatment ONLY** at the time of request and such treatment must be within 60-90 days of breast cancer surgery. Individuals receiving any other type of treatment related to their breast cancer diagnosis do not meet our guidelines for assistance.
5. Requests **must** include the following (with no exceptions):
 - a. A completed application form,
 - b. A properly executed medical confirmation letter from your physician currently overseeing your treatment **of chemotherapy and/or radiation regimens only;** and
 - c. Copies of utility bill(s) you are seeking assistance for that are in **suspension, cut-off or termination status ONLY and date of such disruption of service is clearly stated.**
6. Every attempt will be made to provide a response to any request within 48 hours during normal weekdays of Monday through Friday upon receipt of request.
 - a. If approval of a request, in part, or in whole is determined by the Review Board, applicant will be notified and payment will be sent directly to service provided.
 - b. If request is denied, a letter of explanation will be sent to the applicant.

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

Date: _____

All Shades of Pink
Attn: Emergency Utility Assistance Fund Committee
P.O. Box 501, Glenn Dale, MD 20769

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: _____

Please mail this letter to the address above or fax to: 1-866-800-0303. Request for the All Shades of Pink Emergency Assistance Fund cannot be processed without receipt of this letter properly executed. Thank you.