Application For Assistance

Please note that Toast Pink can only consider applicants whose primary residence is located in the following Counties (please check one):

□ Atlantic □ Burlington □ Cape May □ Cumberland □ Gloucester □ Ocean □ Salem

In order for your Application to be reviewed, all of the following must be completed and provided:

□ **Application Form (Two Pages)**
□ **Doctor's Letter (On Letterhead)**
□ **HIPAA Form**
□ **Assistance Request - 3 Options required w/ current statements reflecting balances, account numbers and remittance addresses.**

Name: _____

Date of Birth: _____

Address: _____

_____

Phone #: _____

Email Address: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Partnered □ Separated

Ethnicity: □ White □ African American □ Latino □ Asian □ Other

Gender: □ Male □ Female

Employment Status Before Cancer Diagnosis:

□ Full Time □ Part-Time □ Disability/Sick Leave □ FMLA □ Unemployed

Please indicate the type of assistance you are looking for Toast Pink to provide:

□ Mortgage □ Rent □ Car Payment □ Utilities □ Insurance

□ Other _____

How did you hear about Toast Pink: _____

PLEASE MAKE CERTAIN ALL REQUIRED INFORMATION HAS BEEN COMPLETED.
INCOMPLETE APPLICATIONS WILL NOT BE REVIEWED/APPROVED.

Medical Information: This section must be completed by your oncology doctor, oncology nurse, licensed social worker, case worked, or patient advocate.

Please return this completed page with a signed letter (on letterhead) verifying your current diagnosis and detailing your treatment plan.

Date of Diagnosis: _____ Primary Cancer: _____

□ New Diagnosis □ Recurrence Current Stage: _____

Is the patient in active Treatment: □ Yes □ No

Please indicate the type of treatment(s) the patient has received in the last twelve months (check all that apply):

□ Chemotherapy □ Radiation □ Surgery □ Hormonal Treatment

Other therapy or treatment details: _____

_____

Form Completed By: _____ _____
Name Title

Office Phone: _____ Email Address: _____

Cell Phone: _____ Fax Number: _____

Hospital/Clinic Name: _____

Address: _____

_____

Note to Applicant: Given the volume of applicants, incomplete applications will not be considered. A member of our vetting committee will contact the applicant to review the outstanding information. The applicant will then have 30 days to submit or the application will be denied.

To submit your application, please email all required items to applications@toastpink.org or mail hard copies to Toast Pink at 7834 Ventnor Avenue, Margate, NJ 08402.

Signature: _____ _____
Date

ASSISTANCE REQUEST

(Please provide 3 Options for Assistance)

Mortgage/Rent

Payee Name: _____

Address: _____

Account #: _____

Amount: $ _____ AutoPay YES NO

Utilities:

Payee Name: _____

Address: _____

Account #: _____

Amount: $ _____ AutoPay YES NO

Utilities:

Payee Name: _____

Address: _____

Account #: _____

Amount: $ _____ AutoPay YES NO

Auto Expenses

Payee Name: _____

Address: _____

Account #: _____

Amount: $ _____ AutoPay YES NO

Other

Payee Name: _____

Address: _____

Account #: _____

Amount: $ _____ AutoPay YES NO

Note: Please make sure the Payee/Applicant/Parent/Guardian Match Invoice/Statement

Please attach a copy of invoice/statement for any requested assistance. Thank you.

HIPAA PRIVACY AUTHORIZATION FORM

I understand that my information, which is retained by TOAST PINK, may not be disclosed to another person without my express written authority. I hereby give authority to my medical provider (named below) to release my (the patient's) health record and/or disclose any and all information as it pertains to my (the patient's) cancer diagnosis and treatment. This information may be used by TOAST PINK to assist in evaluating my (the patient's) eligibility for assistance from the organization. Assistance could be defined as financial, domestic, transportation or other, as I (the patient) may request.

Patient's Name:

Date of Birth:

Medical Provider:

TO: TOAST PINK
7834 Ventnor Avenue
Margate, New Jersey 08402
(609) 805-1107

This authorization expires on or ONE YEAR from the date signed below, whichever is less. I understand that upon this expiration date, my medical provider(s) will no longer provide my information to TOAST PINK and that if I wish for this organization to continue to receive information, I must execute another authorization form.

I understand that if the above named person is not a health care provider or part of a health plan covered by Federal privacy regulations, my health information may be re-disclosed by the person I have named above and will no longer be protected by these regulations. However, the person named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality requirements.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance of my authorization. The revocation will be effective on the date that the TOAST PINK employee who received this Authorization receives the revocation.

Signature (Or Mark) of Patient, Parent of Minor Child, Legal Guardian or Attorney-in-Fact:

Date: __ Telephone Number: __

Name of Parent of Minor Child, Legal Guardian or Attorney-in-Fact (Copy of Valid Appointment of Guardianship or Power of Attorney must be attached):

If Mark is used in place of signature, the Mark must be witnessed:

Witness Signature:

Witness Name/Title: