SEYMOUR PINK
A COMMUNITY'S FIGHT AGAINST BREAST CANCER

Mission Statement

The mission of Seymour Pink, Inc. is to unite a community in the fight against breast cancer. Through fundraising efforts, our goal is to fund breast cancer research, provide education and to empower and assist breast cancer victims and their families**.** Seymour Pink, Inc. assists breast cancer patients regardless of age, gender, race or religion.

How We Help

Financial assistance is granted to patients who meet Seymour Pink's criteria. These funds are used to offset expenses associated with breast cancer. Seymour Pink believes that by easing the burden of debt, the breast cancer patient can focus on recovery. Seymour Pink Inc. is a 501c(3) nonprofit breast cancer organization located in Seymour, CT. Maximum awards may be up to $1,000.00 per year.

To be eligible for financial assistance you **MUST**:

- Be a breast cancer patient currently receiving treatment, and a resident of Seymour, CT or surrounding towns. (*For a list of supported towns see page 5*)
- Provide proof of residency. Any bills submitted for consideration for financial assistance must have the patient's residency address on it. (*For additional information or types of approved documents see page 6*)
- Provide proof of identification with a copy of a State of Connecticut issued and unexpired photo identification.

Please note: An application is **NOT a guarantee of receiving financial assistance. Funds are limited and based on eligibility and availability. **

Please send your request form and copies of bills and receipts to: Seymour Pink Inc.
P.O. Box 333
Seymour, CT 06483

All applications MUST be received by the 20th of the month in order to be considered at the following Seymour Pink board meeting. You will receive a response indicating whether your request has been approved or denied.

Incomplete forms or those missing vital document copies may delay the processing of your application.

Seymour Pink, Inc. is required by law to protect your health information. By signing this document, you authorize Seymour Pink, Inc. to use your health information for the sole purpose of determining eligibility for financial assistance. Seymour Pink, Inc. needs these records to show we are fair and ethical in our application process and to legally make sure you meet the criteria of our mission statement.

I have read and understand the above statement.

Signature: _____ Date: _____

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APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION (please print clearly) Date:_____

First name:_____ Last name:_____

Address:_____ City, State, Zip:_____

Phone number: Home: ( )_____ Work: ( )_____

Cell: ( )_____ Email Address:_____

Date of birth:_____ ☐ Male ☐ Female Marital Status ☐ Single ☐ Married

If patient is a minor (under18), name of parent/guardian:_____

Signature of parent/guardian:_____

MEDICAL INFORMATION *** THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGIST ***

Diagnosis:_____ Date of Diagnosis_____ Current Stage_____

Is patient in active treatment? ☐ Yes ☐ No

To be eligible for financial assistance patient **MUST** be a breast cancer patient currently receiving treatment and a resident of Seymour, CT or surrounding towns.

TREATMENT PLAN

☐ Chemotherapy ☐ Radiation ☐ Surgery ☐ Other_____

*****PLEASE COMPLETE ALL FIELDS ABOVE*****

HEALTH CARE PROFESSIONAL INFORMATION (please print):

Oncologist name:_____ Hospital/clinic:_____

Address:_____ City, State, Zip:_____

Phone: ( )_____ Fax: ( )_____

Signature of Oncologist:_____

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED

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APPLICANT'S NAME:_____ **DOB:**_____

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? ☐ Yes ☐ No

If yes, please indicate type of insurance (check all that apply):

☐ Private insurance ☐ Medicaid ☐ Medicare ☐ Secondary Ins. ☐ Other _____

Are prescription drugs covered? ☐ Yes ☐ No Copay Amount:_____

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ☐ Yes ☐ No Number of dependents:_____
Is patient currently working? ☐ Yes ☐ No ☐ N/A
FAMILY INCOME SOURCES (please check all that apply):

☐ Social Security (Retirement) ☐ Salary ☐ Pension
☐ Public assistance ☐ Short-term disability ☐ SSD (Disability)
☐ Family/friends provide support ☐ Unemployment ☐ SSI
☐ Other –specify_____

****Acceptable Proof of Income:** ****

First two pages of signed copy of Income tax return (please blacken social security number)

OR

Copies of most recent pay check, unemployment check, or SSI, SSD, public assistance benefit notification

TOTAL ANNUAL FAMILY INCOME:**_____

****Application will not be processed if this information is not provided****

Please be aware that funds are limited and based on availability as well as on meeting Seymour Pinks eligibility requirements. An application is NOT a guarantee of receiving financial assistance.

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APPLICANT'S NAME:_____ **DOB:**_____

FINANCIAL NEEDS:

Please list below, in order of priority, your financial needs. Seymour Pink, Inc. will make every effort to approve your request or a portion of your request. If your request is approved, Seymour Pink, Inc. will make the check payable directly to the provider. Please send **CURRENT** copies of bills and receipts with application and retain the originals for your file. Once a decision is made, you will receive notification as to whether your request was approved or denied.

	Financial Need	Amount Requested	Check Payable to:
1.			
2.			
3.			
4.			
5.			

I certify that the above information is true and complete to the best of my knowledge.

Signature:_____ Date:_____

Seymour Pink, Inc. will assist individuals who are currently receiving treatment for breast cancer. The decision on the course of treatment is the sole responsibility of the individual with breast cancer and his or her medical team. Seymour Pink, Inc. bears no responsibility for a patient's decision regarding treatment options.

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List of Supported Towns

Town of Seymour

Immediate Towns:

Ansonia
Beacon Falls
Derby
Naugatuck
Oxford
Shelton

Next Level of Towns:

Bethany
Cheshire
Hamden
Middlebury
Milford
Monroe
New Haven
Newtown
Orange
Prospect
Southbury
Trumbull
Woodbridge

Next Level of Towns:

Bethel
Branford
Bridgewater
Brookfield
Danbury
East Haven
New Fairfield
North Branford
North Haven
Roxbury
Southington
Wallingford
Waterbury
Watertown-Oakville
West Haven
Woodbury
Wolcott

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Residency Documentation Information

You must provide two (2) different pieces of mail from two (2) different sources to prove your home is located in Connecticut. The documents do not need to include a postmarked envelope and may have been sent to a P.O. Box or by email. Both documents must:

- **Show your name and your Connecticut residence address**
- **Be dated within 60 days (unless stated otherwise below)**
- **Be computer generated (typed)**

Acceptable types of documents

- Bill from a bank or mortgage company, utility company, credit card company, doctor or hospital
- Bank statement or bank transaction receipt showing the bank's name and mailing address
- Pre-printed pay stub showing your employer's name and address
- Property or excise tax bill, or Social Security Administration or other pension or retirement annual benefits summary statement and dated within the previous 12 months
- Medicaid or Medicare benefit statement
- Current valid homeowner's, renter's policy or motor vehicle insurance card or policy dated within the previous 12 months
- Current valid Connecticut motor vehicle registration
- Current motor vehicle loan statement for a motor vehicle registered in your name
- Residential mortgage or similar loan contract, lease or rental contract showing signatures from all parties needed to execute the agreement and dated within the previous 12 months
- Connecticut voter registration card
- Change-of-address confirmation from the United States Postal Service showing your prior and current address (Form CNL107)
- Official school records showing enrollment