Friends of Pink – Patient Assistance Fund Application

Our mission: Cattlemen's Days Tough Enough to Wear Pink (TETWP) is dedicated to providing local funding for breast cancer awareness, prevention, education, support, breast screenings and equipment.

Date: _____

Name: _____

Address: _____

City: _____ State: _____Zip: _____

Phone (H): _____ (W): _____ (M):_____

Date Of Birth: _____ SSN: _____

Marital Status: Single Married Divorced Widow

Health Insurance Provider: _____

Employer: _____ Occupation: _____

Please List Your Dependents:

Name	Age	Relationship

Living Arrangements: ____ Own ____ Rent ____ Residing with Family/Friends

Amount Requested: $_____

What will the funds be used towards?

_____

_____

Average Monthly Income: $_____

Source Of Income: ____ Employment ____ Social Security ____ Retired

Other/Explain: _____

Average Monthly Expenses: $ _____

Please Detail Expenses:

Mortgage/Rent: _____ Utilities: _____ Groceries: _____

Insurance: _____ Loans: _____ Medical:_____

Other/Explain:

_____

_____

_____

_____

Other Resources for Assistance: (Check resources listed below that you have sought assistance)

_____ Veterans Benefits _____ Social Security _____ Department of Social Services

_____ Social Services _____ Church _____ Living Journeys

_____ Other/Explain:_____

Please Describe Assistance Given:

_____

_____

_____

Please state the reason for which funds are needed:

_____

_____

_____

_____

Please list the physicians involved in your care:

_____

_____

_____

_____

Please describe your current medical condition:

_____

_____

_____

Do you need to travel for any breast cancer medical appointments? We have Tuffy the TETWP Transportation Truck for those who need it. It can be checked out by you or a family member. The driver must have a valid driver's license. We can also arrange for a volunteer to drive you if needed.

_____
_____
_____
_____
_____

I verify that the above information is true and correct to the best of my knowledge, and agree Tough Enough to Wear Pink may use my information for as necessary for data analysis, reporting, grant writing purposes, and as required to be disclosed by applicable laws.

Please have representation from referring agency, or doctor's office, complete the information below:

Referral made by: _____ Phone: _____

Patient Evaluation by: _____ Date: _____

Recommendations: _____

_____

_____

Signature of Physician:

_____

Signature of Applicant: _____

Please attach a copy of proof of citizenship: Birth Certificate, SSN with Drivers License or Passport.

Please Mail To: Tough Enough to Wear Pink

P.O. Box 1203

Gunnison, CO. 81230

Please contact Heidi Bogart – TETWP Executive Director with any questions.

Email: heidi.interiorvisions@gmail.com Phone: 970 209-6332