Pink Heals Financial Request Form

Our mission is to financially and emotionally assist women, men and children battling any type of cancer in Manitowoc County.

To be eligible for financial assistance, you must currently be receiving treatment for cancer or in Hospice for a cancer diagnosis and live in Manitowoc County.

Applicant's Name:_____ Date of birth:_____

Address:_____ City:_____ County:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Person completing form:_____ Relationship to Applicant:_____

Home Phone:_____ Date of application:_____

Name of another person and phone number we may contact if we are unable to reach you:

Name:_____ Phone: _____

Bills I Need Help With	Amount	Insurance Paid

Please send copies of bills/receipts with application to receive payment. Please send copies only and retain the original bills/receipts for your files. If your request is approved, Pink Heals Manitowoc County, WI will make the check payable to the clinic, hospital, utility, etc. By our policy, we are not able to make checks payable to the applicant. We must pay a bill directly to the entity it is owed. The check will be given to you, and it is your responsibility to distribute the checks to the appropriate places. Please allow up to 3 months for your application to be approved.

Where did you obtain this form from:_____

Briefly add any other information that you think would be helpful for the committee:_____

_____

_____

_____

This section must be completed by Oncologist/Surgeon

_____is a patient of mine and is currently receiving treatment for cancer.
(Patient's Name)

Location of Treatment (Clinic & City): _____

Type of Cancer: _____

Stage of Cancer: _____ Stage I _____ Stage II _____ Stage III _____ Stage IV _____ Other

Date of Diagnosis: _____

The patient must currently be undergoing treatment for a cancer diagnosis.

Type of treatment and date of latest treatment: _____

_____

Doctor's Signature: _____ Date: _____

Doctor's Name (print): _____ Doctor's phone #: _____

I authorize a representative from Pink Heals Manitowoc County, WI to verify with my physician or staff that I am in treatment for cancer.

Applicant's signature:_____ Date:_____

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

Applicants Signatures:_____ Date:_____

If you have questions, please call our Direct Care Assistance Coordinator at 920-755-4220, ask for Ann.

Mail this form with all your receipts to: Pink Heals Manitowoc County, WI
PO Box 1961, Manitowoc, WI 54221-1961

Email: mishicotwipinkheals@gmail.com
Facebook: Pink Heals Mishicot WI
Website: pinkheals.us