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 undergoing active treatment for cancer, undergoing reconstructive surgery directly related to the cause of the cancer, or be receiving Hospice care.

Applicant's Name:_____________________________________ Date of Birth:_________________

Address: ___________________________ City: ____________________ County: _________________ Zip:________

Home phone: ________________ Cell phone: _______________ Work phone: ____________________

Person completing the form: __________________________________ Relationship to Applicant: ______________

Phone: _______________________________ Have you been previously helped? Year: _______________

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

Name: ____ Phone: ________________________________

Bills I Need Help With	Amount	Insurance Paid

Please attach 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.

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

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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 I ____ Stage II ____ Stage III ____ Stage IV ____

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 Signature: ____ Date: _______________

If you have questions, please call our Direct Care Assistance Coordinator at (920) 323-6133, ask for Bonnie.

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

Web site: pinkheals.us
Facebook: Pink Heals of Manitowoc County
Phone: (920) 663-2789