APPLICATION FORM FOR ASSISTANCE

Name: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

_____

Home Phone Number: _____ Cell Phone Number: _____

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

If employed, please provide the name and address of your Employer:

_____

_____

Employment Address After 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 (Check all that apply):

□ Financial Assistance □ Transportation □ Domestic Living Expense □ Child Care

Medical Information: This section must be completed by your oncology doctor, oncology nurse, licensed social worked, case worker or patient advocate. Please return this completed page along 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 past twelve months:

(Check all the 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: _____

_____

Signature: _____

ASSISTANCE REQUEST

Mortgage/Rent
Payee Name:

Address: Account

#: Amount: $

Utilities:
Payee Name:

Address: Account

#: Amount: $

Utilities:
Payee Name:

Address: Account

#: Amount: $

Auto Expenses

Payee Name:

Address: Account

#: Amount: $

Other

Payee Name:

Address: Account

#: Amount: $

Notes:

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: _____