APPLICATION FORM FOR ASSISTANCE

Name:

Date of Birth:

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 Status 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

How did you hear about Toast Pink:

Please complete and provide the following:

- ☐ Application Form
- ☐ Doctor's Letter (On Letterhead)
- ☐ HIPAA Form
- ☐ Assistance Request Form (Please provide 3 Options for Assistance)

Send all forms to:
Toast Pink
7834 Ventnor Ave
Margate City, NJ 08402

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:

Please make certain all information has been completed. Incomplete applications will not be accepted.

ASSISTANCE REQUEST
(Please provide 3 Options for Assistance)

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:

Please attach a copy of invoice/statement for any requested assistance. Thank you.