



Mission Statement

The mission of Seymour Pink, Inc. is to unite a community in the fight against breast cancer. Through fundraising efforts, our goal is to fund breast cancer research, provide education and to empower and assist breast cancer victims and their families. Seymour Pink, Inc. assists breast cancer patients regardless of age, gender, race or religion.

How We Help

Financial assistance is granted to patients who meet Seymour Pink's criteria. These funds are used to offset expenses associated with breast cancer. Seymour Pink believes that by easing the burden of debt, the breast cancer patient can focus on recovery. Seymour Pink Inc. is a 501c(3) nonprofit breast cancer organization located in Seymour, CT. Maximum awards may be up to \$3,000.00 per year.

To be eligible for financial assistance you **MUST**:

- Be a breast cancer patient currently receiving treatment, and a resident of Seymour, CT or surrounding towns. *(For a list of supported towns see page 5)*
- Provide proof of residency. Any bills submitted for consideration for financial assistance must have the patient's residency address on it. *(For additional information or types of approved documents see page 6)*
- Provide proof of identification with a copy of a State of Connecticut issued and unexpired photo identification.
- Application ***must*** include a signed letter from a Social Worker, Nurse, Healthcare Navigator or treating Physician on letterhead with a statement explaining the need for financial assistance.

****Please note: An application is NOT a guarantee of receiving financial assistance. Funds are limited and based on eligibility and availability. ****

Please send your request form and copies of bills and receipts to: Seymour Pink Inc.
P.O. Box 333
Seymour, CT 06483

All applications **MUST** be received by the 20th of the month in order to be considered at the following Seymour Pink board meeting. You will receive a response indicating whether your request has been approved or denied.

Incomplete forms or those missing vital document copies may delay the processing of your application.

Seymour Pink, Inc. is required by law to protect your health information. By signing this document, you authorize Seymour Pink, Inc. to use your health information for the sole purpose of determining eligibility for financial assistance. Seymour Pink, Inc. needs these records to show we are fair and ethical in our application process and to legally make sure you meet the criteria of our mission statement.

I have read and understand the above statement.

Signature: _____ Date: _____



SEYMOUR PINK
A COMMUNITY'S FIGHT AGAINST BREAST CANCER

APPLICATION FOR FINANCIAL ASSISTANCE

PATIENT INFORMATION

(please print clearly)

Date: _____

First name: _____ Last name: _____

Address: _____ City, State, Zip: _____

Phone number: Home: () _____ Work: () _____

Cell: () _____ Email Address: _____

Date of birth: _____ Male Female Marital Status Single Married

If patient is a minor (under18), name of parent/guardian: _____

Signature of parent/guardian: _____

MEDICAL INFORMATION

*** **THIS SECTION MUST BE COMPLETED BY YOUR ONCOLOGIST** ***

Diagnosis: _____ Date of Diagnosis _____ Current Stage _____

Is patient in active treatment? Yes No

To be eligible for financial assistance patient **MUST** be a breast cancer patient currently receiving treatment and a resident of Seymour, CT or surrounding towns.

TREATMENT PLAN

Chemotherapy Radiation Surgery Other _____

****PLEASE COMPLETE ALL FIELDS ABOVE****

HEALTH CARE PROFESSIONAL INFORMATION (please print):

Oncologist name: _____ Hospital/clinic: _____

Address: _____ City, State, Zip: _____

Phone: () _____ Fax: () _____

Signature of Oncologist: _____

INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED



SEYMOUR PINK
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APPLICANT'S NAME:

DOB: _____

THIS PAGE TO BE COMPLETED BY THE PATIENT/PERSON REQUESTING FINANCIAL ASSISTANCE

HEALTH INSURANCE INFORMATION

Does the patient have health insurance? Yes No

If yes, please indicate type of insurance (check all that apply):

Private insurance Medicaid Medicare Secondary Ins. Other

Are prescription drugs covered? Yes No Copay Amount: _____

HOUSEHOLD FINANCIAL INFORMATION

Is patient currently employed? ____ Yes ____ No Number of dependents:

Is patient currently working? ____ Yes ____ No ____ N/A

FAMILY INCOME SOURCES (please check all that apply):

- Social Security (Retirement) Salary Pension
- Public assistance Short-term disability SSD (Disability)
- Family/friends provide support Unemployment SSI
- Other –specify _____

****Acceptable Proof of Income:****

First two pages of signed copy of Income tax return (please blacken social security number)

OR

Copies of most recent pay check, unemployment check, or SSI, SSD, public assistance benefit notification

TOTAL ANNUAL FAMILY INCOME:** _____

****Application will not be processed if this information is not provided****

Please be aware that funds are limited and based on availability as well as on meeting Seymour Pinks eligibility requirements. An application is NOT a guarantee of receiving financial assistance.



SEYMOUR PINK
A COMMUNITY'S FIGHT AGAINST BREAST CANCER

APPLICANT'S NAME:

DOB: _____

FINANCIAL NEEDS:

Please list below, in order of priority, your financial needs. Seymour Pink, Inc. will make every effort to approve your request or a portion of your request. If your request is approved, Seymour Pink, Inc. will make the check payable directly to the provider. Please send **CURRENT** copies of bills and receipts with application and retain the originals for your file. Once a decision is made, you will receive notification as to whether your request was approved or denied.

Financial Need

Amount Requested

Check Payable to:

- 1 .
- 2 .
- 3 .
- 4 .

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

Signature: _____ Date: _____

Seymour Pink, Inc. will assist individuals who are currently receiving treatment for breast cancer. The decision on the course of treatment is the sole responsibility of the individual with breast cancer and his or her medical team. Seymour Pink, Inc. bears no responsibility for a patient's decision regarding treatment options.

Seymour Pink Inc. ~~~~ P.O. Box 333~~~~ Seymour, CT 06483



List of Supported Towns

Town of Seymour

Immediate Towns:

Ansonia	Naugatuck
Beacon Falls	Oxford
Derby	Shelton

Next Level of Towns:

Bethany	Newtown
Cheshire	Orange
Hamden	Prospect
Middlebury	Southbury
Milford	Trumbull
Monroe	Woodbridge
New Haven	

Next Level of Towns:

Bethel	North Haven
Bethlehem	Plymouth
Branford	Roxbury
Bridgewater	Southington
Bristol	Stratford
Brookfield	Thomaston
Danbury	Wallingford
East Haven	Waterbury
Meriden	Watertown-Oakville
Morris	West Haven
New Fairfield	Woodbury
North Branford	Wolcott



Residency Documentation Information

You must provide two (2) different pieces of mail from two (2) different sources to prove your home is located in Connecticut. The documents do not need to include a postmarked envelope and may have been sent to a P.O. Box or by email. Both documents must:

- **Show your name and your Connecticut residence address**
- **Be dated within 60 days (unless stated otherwise below)**
- **Be computer generated (typed)**

Acceptable types of documents

- Bill from a bank or mortgage company, utility company, credit card company, doctor or hospital
- Bank statement or bank transaction receipt showing the bank's name and mailing address
- Pre-printed pay stub showing your employer's name and address
- Property or excise tax bill, or Social Security Administration or other pension or retirement annual benefits summary statement and dated within the previous 12 months
- Medicaid or Medicare benefit statement
- Current valid homeowner's, renter's policy or motor vehicle insurance card or policy dated within the previous 12 months
- Current valid Connecticut motor vehicle registration
- Current motor vehicle loan statement for a motor vehicle registered in your name
- Residential mortgage or similar loan contract, lease or rental contract showing signatures from all parties needed to execute the agreement and dated within the previous 12 months
- Connecticut voter registration card
- Change-of-address confirmation from the United States Postal Service showing your prior and current address (Form CNL107)
- Official school records showing enrollment