UNITED COLORS OF PINK
10104 Hartford Ct Unit 2A
Schiller Park IL 60176

THE PINK HELPING HAND PROGRAM

Eligibility and Review Process:

• United Colors of Pink approves requests for limited medical and non-medical expenses.

• Non-medical expenses include, but not limited to, and transportation, groceries, cleaning services.

• Depending on the type of assistance requested, additional documentation may be required.

• United Colors of Pink selection committee will meet once a month to review submitted applications. Our review process may take 4-6 weeks.

• Requests will ONLY be reviewed once all documents, including bills and medical reports are received. Incomplete applications will not be reviewed.

• The selection committee sets the eligibility criteria and has final determination in all cases.

• Assistance is granted on a first-come, first-serve basis to the extent funding is available.

• The Pink Helping Hand Program may only be able to assist a portion of the potential recipients who apply for aid.

• If approved, payment will be made directly to the vendor rendering services on behalf of the patient. No checks will be written to the applicant.

• United Colors of Pink reserves the right to refuse service to anyone.

• Assistance will be terminated if any untrue or falsified information has been submitted

ALL APPLICATIONS SHOULD BE MAILED TO:

United Colors of Pink

10104 Hartford Ct. Apt 2A

Schiller Park, Il 60176

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10104 Hartford Ct Unit 2A
Schiller Park IL 60176

The Pink Helping Hand Assistance Request Form

Received: _____By Whom: _____Date of Application_____

First Name_____ M.I.____ Last Name_____

Address_____Apt.#_____
City_____ County _____State _____Zip Code_____

Date of Birth (MM/DD/YYYY) _____/_____/_____ Phone (_____) _____

***An email address is required for all follow-up communication. Please check your email weekly during the application process. You may appoint someone else as your email contact person if you don't have email access.

Email _____ *** REQUIRED

(Please print very clearly, we only communicate with applicants via email, so if we can't read your email address, you may not hear from us.) Name of email account holder (if not applicant):

_____

Relationship to applicant: _____

1. How did you hear about United Colors of Pink?

_____

2. Have you met with a United Colors of Pink representative? ___ Yes ___ No (if no, we will contact you to schedule your appointment)

3. Ethnicity (optional, for data collection purposes only)

_____

4. Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated (please check one)

5. Health Insurance: ___Medicare ___ Medicaid ___Private Insurance ___COBRA___ Other (supplements or secondary) _____ (check all that apply).

6. Date of breast cancer diagnosis_____

7. Current Treatment: ___ Surgery ___ Chemotherapy ___ Radiation ___ Other

8. Are you a US citizen, living in the United States? _____

9. Total # of people living in household _____ # adults_____ # minors_____

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10. Type of support requested ____ Medical (___ Physician co-pays, ___ Surgical costs) ____ Non-Medical (____ Housing, ____ Utilities)

11. Amount Requested _____ (amount may not exceed $2500 and must have documentation/statements that support amount requested)

Please understand we are not an emergency fund and cannot provide immediate assistance.

Meeting the guidelines and applying to the Pink Helping Hand Program does not guarantee funds will be available or offered.