



Pink Hands of Hope Helping Hands Application

APPLICANT INFORMATION

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ e-mail: _____

Date of Birth d/m/y: _____

Who referred you to Pink Hands of Hope? _____

DIAGNOSIS AND HEALTH INSURANCE INFORMATION

Type of Cancer: _____ Date of Diagnosis: _____

Treatment Doctor/Surgeon: _____ Phone: _____

Address: _____

Primary Oncologist: _____ Phone _____

Address: _____ City _____ St _____ Zip _____

Do you have health insurance Y N

If yes, please indicate name of primary insurance: _____

FINANCIAL INFORMATION

Has your diagnosis affected your ability to remain employed? Y N

How many unpaid MEDICAL BILLS do you currently have outstanding? (Please list debtors and amounts below , include out of pocket treatment, prescription, etc.)

By signing below, you give permission to Pink Hands of Hope to contact your medical professionals regarding your medical and financial information:

Your Signature:

Today's Date

Please return application to: Pink Hands of Hope 5325 E. Trindle Rd. Mechanicsburg PA 17050 Questions? Call 717-620-8264 Email: info@pinkhandsofhope.org

*Pink Hands of Hope is a non-profit organization whose mission is to assist people battling cancer. The Helping Hands program is designed to help patients with mounting medical bills. Approval of applicants is based on availability of funds for this program.

Helping Hands of Hope Program

Instruction Page

Pink Hands of Hope is a non-profit organization whose mission is to assist people battling cancer, with a focus on breast cancer. The “Helping Hands” program is intended to help patients with mounting medical bills only not covered by health insurance or grants. Approval of applicants is based on availability of funds for this program.

**You must reside in one of the participating counties, Adams, Cumberland, Dauphin, Franklin, Fulton
Juniata, Lancaster, Lebanon, Perry, Schuylkill, Snyder, or York.**

Step 1: If you are a cancer patient with unpaid medical bills (not covered by insurance or grants), please complete the application and return it to Pink Hands. This can be returned via mail, email or in person to

Pink Hands of Hope

5325 E. Trindle Rd.

Mechanicsburg, PA 17050

Or the application can be scanned/mailed to info@pinkhandsofhope.org.

Step 2: Once the application is received and reviewed, it will be forwarded to the Pink Hands Board of Directors for approval (based on availability of funds) up to \$1500. Please note this step is completed within a very short period.

Step 3: When the approval is complete, you will be contacted by Pink Hands of Hope to discuss payment of the outstanding medical bill(s).

Step 4: Once we have received the copies of the outstanding medical bills, Pink Hands will cut check(s) directly to your provider.

If you have any questions regarding this application process, or any other questions for Pink Hands of Hope, feel free to email us at info@pinkhandsofhope.org or call at 717-620-8264.