MILES OF HOPE APPLICATION

(Please Print)

Today's Date: ______________________

Patient Name: ________________________________ Phone: ________________________________

Address: ____

Email: ____

Type of Cancer: ___________________________________

Date Treatment Began* ________________________________ End Date* ________________________

How often do you have treatment ____

Have you received products/services from Pink Hands of Hope in the past? Yes________ No __________

If so, what did you receive? ____

How did you hear about Miles of Hope? ____

Patient Signature: ____

Cancer Health Care Provider Name:____

Health Care Provider Address: ____

Health Care Representative Signature**: ____

Health Care Representative Phone: ____

*Approximate Date ** Healthcare provider can be doctor/care coordinator/nurse navigator.

This program is intended for breast cancer patients that are CURRENTLY IN ACTIVE TREATMENT. You must reside in in one of the participating counties, Adams, Cumberland, Dauphin, Franklin, Fulton, Juniata, Lancaster, Lebanon, Perry, Schuylkill, Snyder and York.

This application must be completely in full to be considered for payment.

Please fill out above and return to: (mail) Pink Hands of Hope 5325 E. Trindle Rd, Mechanicsburg PA 17050. (scan/email) info@pinkhandsofhope.org Question? 717-620-8264

For office use only

Cards given/mailed (amount) ____________________________ Date given/Mailed ______________________________

Pink Hands of Hope Representative:____

11/2022