APPLICATION FOR FINANCIAL AID

Updated February 2021

PLEASE READ & COMPLETE IN FULL
TO BE SIGNED BY PATIENT AND MEDICAL PROFESSIONAL

Application can be submitted via email to littlepinkgift @gmail.com; mailed to c/o Lynda Lewis, 63 Avocado, The Villages at Coverley, Ch. Ch.; or delivered by hand to Halton Graphics Ltd, Newton Industrial Park, Ch Ch. Monday - Friday 8.30-4.00pm.

All applications must be accompanied by a copy of the patient's Barbados I.D. Card. All applications and medical information is treated in the strictest confidence.

APPLICANTS ARE INVITED TO ATTEND OUR BOSOM PALS' SUPPORT GROUP MEETINGS. These are held the 3rd Saturday of every month, January to November at St. Dominic's Church Hall, Dover, Ch. Ch., 2pm - 4pm. Call Andrea McKenzie at 428-8692 for details.

SURNAME.. FIRST NAME.. MIDDLE NAME...

DATE OF BIRTH... COUNTRY OF BIRTH....................................... COUNTRY OF RESIDENCY...............................

HOME ADDRESS..

BARBADOS ID#... EMAIL ADDRESS...

ARE YOU EMPLOYED Y N EMPLOYER NAME...OCCUPATION.................................

ARE YOU SELF EMPLOYED Y N EMPLOYER ADDRESS...

TELEPHONE NUMBERS: (H) .... (W) .... (C) ....

DO YOU HAVE HEALTH INSURANCE Y N HEALTH INSURANCE CARRIER..

HAVE YOU PREVIOUSLY APPLIED FOR AID? Y N IF YES, APPROXIMATE DATE & AMOUNT.........................

HAVE YOU BEEN DIAGNOSED WITH BREAST CANCER? Y N IF YES, APPROXIMATE DATE...

HAVE YOU HAD A BIOPSY OR SURGERY? Y N IF YES, APPROXIMATE DATE...

PHYSICIAN / MEDICAL PROFESSIONAL: *Briefly outline current medical plan of treatment and aid applied for. Please be specific regarding test, drugs, cost, etc. Include vendor names*..

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TYPE OF AID	VENDOR	COST	TYPE OF AID	VENDOR	COST
BONE SCAN			LYMPHODEMA CONSULT		
BIOPSY			LYMPHODEMA SUPPLIES		
CT SCAN			CHEMOTHERAPY		
ECHOCARDIOGRAM			PROSTHESIS CONSULT		
ELECTROCARDIOGRAM			GEL PROSTHESIS		
DRUGS			MASTECTOMY BRA		
HISTOLOGY			HOSPITAL FEE		
LABORATORY FEE			OTHER		
SURGERY			OTHER		
DOCTOR'S FEE					
X-RAY					
FISH TEST					
IMMUNOHISTOCHEMISTRY					

The Little Pink Gift Foundation does not provide medical services and does not accept responsibility for the medical care of patients. Patients remain under the care and supervision of their promary physician(s). The undersigned hereby certifies that all information provided in this application is true, complete and accurate, and acknowledges that such information will be used by the Foundation to determine the undersigned's eligibility for funding. The Little Pink Gift Foundation gives no guarantee that applicants will be successful in receiving funding. The decision of the Foundation is final.

MEDICAL PROFESSIONAL SIGNATURE: ***PATIENT SIGNATURE:***

DATE: ***DATE:***

OFFICE STAMP: