APPLICATION FOR
HELPING HANDS AND MILES OF HOPE

The ***Helping Hands*** and ***Miles of Hope*** programs serve residents from the following counties: **Adams, Cumberland, Dauphin, Franklin, Fulton, Lancaster, Lebanon, Perry, or York.**

- The ***Helping Hands*** program helps **cancer patients** with bills not covered by health insurance or grants. To apply for Helping Hands assistance, please complete **Parts I, II, III, and V** of this application.
- The ***Miles of Hope*** program provides gas gift cards for **patients receiving treatment for breast cancer only.** To apply for Miles of Hope assistance, please complete **Parts I, II, IV, and V** of this application.
- If you are eligible for both programs, please complete all five parts of the application.

Upon completion, please return the form to ***Pink Hands of Hope, 5325 East Trindle Road, Mechanicsburg, PA 17050 or email a scanned copy to info@pinkhandsofhope.org.*** If you have questions regarding the application, please call 717-620-8264 or email info@pinkhandsofhope.org.

PART I – APPLICANT INFORMATION

FIRST NAME	LAST NAME		
STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTY OF RESIDENCE *(circle one)*

Adams Cumberland Dauphin Franklin Fulton Lancaster Lebanon Perry York

HOME PHONE	MOBILE PHONE

EMAIL ADDRESS	BIRTHDATE	GENDER *(circle one)*
		Male Female

RACE/ETHNICITY *(circle one)*

Caucasian Hispanic Black/African American Asian/Indian/Pacific Islander Other _____

REFERRED BY *(circle one)*

Friend Family Physician's Office Other _____

PART II – DIAGNOSIS INFORMATION

TYPE OF CANCER *(circle one)*	DATE OF DIAGNOSIS
Breast Cervical Uterine Ovarian Lung Colon Other Cancer	

HEALTH CARE SYSTEM FOR CANCER TREATMENT *(circle one)*

UPMC West Shore	Penn State Health (Hershey)	Geisinger
UPMC York	Penn State Health (Holy Spirit)	Wellspan York Hospital
UPMC Carlisle	Penn State Health (Hampden Medical Center)	Wellspan Good Samaritan
UPMC Hanover	Penn Medicine (Lancaster General Health)	Wellspan Gettysburg Hospital
UPMC Community Osteopathic	Other_____	

	NAME	PHONE		
PRIMARY ONCOLOGIST	STREET ADDRESS	CITY	STATE	ZIP CODE
TREATMENT DOCTOR OR SURGEON	NAME	PHONE		
	STREET ADDRESS	CITY	STATE	ZIP CODE

PART III– HEALTH INSURANCE AND FINANCIAL INFORMATION FOR HELPING HANDS PROGRAM

DO YOU HAVE HEALTH INSURANCE? *(circle one)*	IF YES, ENTER THE NAME OF THE PRIMARY INSURANCE COMPANY USED TO COVER YOUR TREATMENT
Yes No	
WERE YOU EMPLOYED PRIOR TO YOUR DIAGNOSIS? *(circle one)*	**IF YES, HOW HAS YOUR DIAGNOSIS IMPACTED YOUR EMPLOYMENT?** *(circle one)*
Yes No	I can't work I work the same number of hours I work less hours

HOW MANY MEDICAL BILLS DO YOU CURRENTLY HAVE OUTSTANDING? LIST DEBTORS AND AMOUNTS BELOW – INCLUDE OUT-OF-POCKET EXPENSES, CO-PAYS, DEDUCTIBLES, PRESCRIPTIONS, ETC. ATTACH AN ADDITIONAL SHEET OF PAPER IF NECESSARY.

NOTE: Once your application for Helping Hands is received and reviewed, it will be forwarded to the Pink Hands of Hope Board of Directors for approval (based on availability of funds). **This step is completed within a very short timeframe.** When the approval is complete, you will be contacted by Pink Hands of Hope to discuss payment of the outstanding medical bill(s). If approved, you will be asked to mail copies of those outstanding medical bills to Pink Hands of Hope, and payment will be made directly to the provider(s) up to the approved amount.

PART IV – RESIDENCE AND TREATMENT INFORMATION FOR MILES OF HOPE PROGRAM (BREAST CANCER PATIENTS ONLY)

HAVE YOU RECEIVED PRODUCTS/SERVICES FROM PINK HANDS OF HOPE IN THE PAST? *(circle one)*	IF YES, WHAT PRODUCTS/SERVICES DID YOU RECEIVE?
Yes No	

WHAT TREATMENT ARE YOU RECEIVING? ***(circle all that apply)***

Chemotherapy Radiation Hormonal Therapy Immunotherapy Other _____

DATE TREATMENT BEGAN	APPROXIMATE DATE TREATMENT IS EXPECTED TO END

FOR OFFICE USE ONLY

CARD AMOUNT	DATE PROVIDED	PINK HANDS OF HOPE REPRESENTATIVE NAME

PART V – SIGNATURES

PATIENT SIGNATURE

WITH MY SIGNATURE, I CERTIFY THE ABOVE INFORMATION TO BE TRUE TO THE BEST OF MY KNOWLEDGE, AND I HEREBY GRANT PERMISSION TO PINK HANDS OF HOPE TO CONTACT THE HEALTH CARE REPRESENTATIVE LISTED IN THIS APPLICATION REGARDING MY MEDICAL AND FINANCIAL INFORMATION

_____ _____

SIGNATURE **DATE**

HEALTH CARE REPRESENTATIVE

WITH MY SIGNATURE, I CERTIFY THAT I AM A MEDICAL PROFESSIONAL (PHYSICIAN, CARE COORDINATOR, NURSE NAVIGATOR, ETC.) INVOLVED IN THE CARE OF THE ABOVE SIGNATORY, AND I CERTIFY THAT THE INFORMATION PROVIDED REGARDING DIAGNOSIS AND TREATMENT IS TRUE

_____ _____

NAME (PLEASE PRINT) **POSITION**

_____ _____

SIGNATURE **DATE**