PINK REVOLUTION OF NEW HAMPSHIRE
Supporting Patients with All Types of Cancer
(207) 210-8334
info@pinkrevolutionofnh.org
www.pinkrevolutionofnh.org
P.O. Box 578, Brookline, NH 03033

# PINK REVOLUTION OF NEW HAMPSHIRE - GRANT APPLICATION

This application is for chemotherapy patients and breast cancer survivors seeking assistance in acquiring products for hair loss, breast surgery, and lymphedema. Eligibility for the grant is open to residents of NH, VT, MA, and ME.

**The information provided in this application will remain confidential.**

## Application information

FULL NAME: _____ _____ _____ Date of Birth: _____
*Last* *First* *M.I.*

ADDRESS: _____ _____ PHONE: _____
*Street address* *Apt/Unit #*

_____
City, State, Zip

EMAIL ADDRESS: _____

Primary Insurance: _____ Secondary Insurance: _____

Are you the subscriber? Yes ☐ No ☐

Are you currently in treatment? Yes ☐ No ☐

If yes, what are you undergoing treatment for? Type your answer here:

Have you been diagnosed with breast cancer? Yes ☐ No ☐

**Check the product(s) for which you are seeking financial assistance: (check all that apply)**

☐ Post Surgical Bra ☐ Lymphedema Products (compression products/swell spots)

☐ Breast Prosthesis ☐ Hair Prosthesis/Wig

Is all or part of this expense covered by your insurance, Medicaid/Medicare, hospital charity care or state/city/town programs? Yes ☐ No ☐

Reason you require assistance. Type your answer here:

Have you applied for assistance before from this fund? Yes ☐ No ☐

If yes, when and what did you receive funding for :

Are you willing to share how Pink Revolution Breast Cancer Alliance of NH has assisted you by providing a testimonial? **Note**: Your answer will not affect grant consideration. Yes ☐ No ☐

I understand that assistance from Pink Revolution Breast Cancer Alliance of NH is available only if I have a financial need not met by other resources.

Yes ☐ No ☐

## Disclaimer and signature

I certify that my answers are true and complete to the best of my knowledge.

Print Medical Professional's Name and Title: _____

Hospital or Medical Affiliated Organization: _____

Medical Professional Phone Number: _____

Medical Professional's Signature _____ DATE _____

Patient's Signature _____ DATE _____

**Once completed, this signed application can either be emailed, faxed or mailed to Amanda Thomas, LLC. Additionally, reach out to your doctor and request a faxed prescription be sent to 603-595-9445 for the products you would like assistance with.**

Amanda Thomas, LLC (www.amanadathomasboutique.com)
30 Daniel Webster Hwy
Suite 1
Merrimack, NH 03054

Fax: 603-595-9445
Email: info@amandathomasboutique.com
603-595-9447 (Business Phone Number)

Once the application is received, you will be contacted by Amanda Thomas, LLC to make an appointment and determine your needs and the cost of your products.

## Completion of this application is not a guarantee of grant.