Pink Patient Assistance Application

The Foundation enables our Stampede family to preserve the western legacy of providing support and assistance to those in need. Elizabeth Stampede Foundation Tough Enough To Wear Pink (TETWP) is dedicated to helping those in our greater community who are battling breast cancer as well as any other form of cancer.

Date: ______________________________

Name:

____

Address:

____

City: ____ State: ___________________Zip:

____

Phone (H): _______________________ (W): ______________________
(M):______________________

Date Of Birth: __________________________ SSN:

____

Marital Status: Single Married Divorced Widow Widower

Health Insurance Provider:

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Employer: _______________________________________ Occupation:

____

Please List Your Dependents:

Name Age Relationship

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Living Arrangements: ____ Own ____ Rent ____ Residing with Family/Friends

Amount Requested: $____

What will the funds be used towards?

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Average Monthly Income: $______________________________________

Source Of Income: ____ Employment ____ Social Security ____ Retired

Other/Explain:

____

Average Monthly Expenses: $ ______________________________________

Please Detail Expenses:

Mortgage/Rent: ___________________ Utilities: ___________________ Groceries: _____________

Insurance: ___________________________ Loans: ______________________
Medical:__________________

Other/Explain:

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Other Resources for Assistance: (Check resources listed below that you have sought assistance)

_____ Veterans Benefits _______ Social Security _____ Department of Social Services

_____ Social Services _____ Church _____ Living Journeys

_____
Other/Explain:____
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Please Describe Assistance Given:

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Please state the reason for which funds are needed:

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Please list the physicians involved in your care:

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Please describe your current medical condition:

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I verify that the above information is true and correct to the best of my knowledge, and agree Elizabeth Stampede Foundation Tough Enough to Wear Pink may use my information as necessary for data analysis, reporting, grant writing purposes, and as required to be disclosed by applicable laws.

Please have representation from referring agency, or doctor’s office, complete the information below:

Referral made by: _______________________________________ Phone: ________________________

Patient Evaluation by: ____________________________________ Date: __________________________

Recommendations: ____

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Signature of Physician:____

Signature of Applicant: ____

Please attach a copy of proof of citizenship: Birth Certificate, SSN with Driver's License or Passport.

Please Mail to: Elizabeth Stampede Foundation
Tough Enough to Wear Pink
PO Box 1062
Elizabeth, CO 80107

Email: Foundation@ElizabethStampede.com