Cedar Valley Cancer Committee – Beyond Pink TEAM
Beyond Pink Fund – Financial Assistance Application

Last Name:_____ First Name: _____ Middle Initial: _____

Address: _____

City: _____, Iowa Zip: _____ County: _____

Phone: _____ Date of Birth: _____ Age: _____

Email address: _____

Race/Ethnicity (circle all that apply): Caucasian (non-Hispanic) Latina/Hispanic African American Asian
American Indian/Alaska Native Native Hawaiian/Pacific Islander Other _____

Health Insurance: None _____ Medicare _____ Medicaid _____ Primary Insurance _____
Insurance Carrier _____ Annual Deductible _____

Information to be shared with Approval Committee:

Total Household Monthly Income (net income/after taxes) _____

# of people living in the home that are dependent on this income? _____

Is monthly income affected by new cancer diagnosis? If yes, Explain _____

Are you currently receiving treatment for breast cancer? YES/NO – type of treatment _____

Is this your first request this calendar year? YES/NO – date of previous request _____

***Services requested*:**
□ Compression Garments □ Post Surgical Bra/Breast Prosthesis □ Medical Bills/Pharmacy/Dr. Visits
□ Basic Living Expenses (groceries, utilities, rent, water, phone, etc). □ Wig(s) □ Transportation/Gas
□ Other (please be specific) _____

Total $ Amount Requested: _____
(For medical requests: include estimate of expense to be incurred or copy of the bill from the health care provider)

Date Assistance needed (if applicable) _____

Statement of Need (why does this person need assistance – please be specific):_____

_____
_____
_____
_____

The Beyond Pink TEAM cannot accept out of state applications. Please do not apply if you live outside of Northeast Iowa.

Signature of Applicant: _____ Date: _____

To begin approval process please email application to:

Angela Hamilton
Email: a.hamilton@cfu.net
Phone: (319) 231-3143

For Office Use Only:
Duplicate Request □Yes □No Amount of this request: _____
Signed NOD on File: □Yes □No Amount Prior Approved: _____ Difference _____
Amount Approved: _____ To: _____
Date of Check Request: _____ By: _____