

Patient Financial Aid Form

The only people allowed to fill out this form are patients, spouse/child, P.O.A., patient navigator or social worker at treatment center. Applications will *not* be accepted if other parties fill out and/or submit this form. If you have any questions or need clarification on anything, contact Marci White at Marci@projectpurple.org. We ask that all documents be in pdf.

Please check one: I am seeking aid for myself I am seeking aid on the patient's behalf

Patient Name:

Patient Address (street, city, state, zip code):

Patient Date of Birth (month/date/year):

Best Contact Number for Patient:

Best Email Address for Patient:

IF YOU ARE *NOT* THE PATIENT YOU MUST FILL OUT YOUR INFORMATION HERE...

Full Name:

Title or Relationship to Patient (if P.O.A. please submit proof):

Best Contact Number:

Best Email Address:

Along with this form, you MUST INCLUDE ALL OF THE FOLLOWING INFORMATION in order for your application to be processed and reviewed:

- Summary report from your last doctor's appointment *or* a recent letter from doctor's office (*See Medical Information Guide for more details*)
- Copies of bills you are requesting to be paid
- Total Household Income - copy of previous year's signed 1040 tax return forms or SSI Benefits letter (*SS, disability, and pension documents not accepted*)
- Copy of Photo ID

Please refer to the PFA Program Guidelines for more detailed information about the required documents listed about.

List all members residing in the household? (please, also, indicate how many of those members are minors)

Living Arrangement (Check which box most accurately represents your living arrangement)

- Currently Renting
- Owner of Residence
- Other – Please Specify _____

Have you received financial aid from any other group or organization? Yes No

If yes, please identify from who and how much?

How did you find the Project Purple Patient Financial Aid program?

Additional Information:

If there is anything further that you would like to share, please do so here. (300 words max)

_____ I give permission for Project Purple to obtain information from my application to go towards their overall statistic findings.

_____ I DO NOT give permission for Project Purple to obtain information from my application to go towards their overall statistic findings.

I hereby certify that the above information and all other contents provided with this application are true and accurate. I understand that any false information may lead to the denial of any grants.

Signature of Patient

Date

Signature of Person Filling Out Form

Date

QUESTIONNAIRE FORM *(not required and will have absolutely no effect on awards granted)*

We take the answers from this survey and enter it into a data base that will provide us with statistics in hope to provide helpful information to scientists as well as knowledge and awareness to the public.

Gender at Birth: M F

Age at time of diagnosis with pancreatic cancer?

Ethnicity?

Religion?

State/Region/Country where you've lived the most of your life?

How many times a week do you exercise for 20min. Or more?

Are you a social smoker or Do you smoke on a regular basis?
If so, either way, how many *packs* would you say you smoke in 1 months' time?

Do you drink alcohol? If so, how many glasses/beers on average per month?

Do you partake in recreational drugs?
If so, what is your drug of choice and how frequent do you engage?

Has anyone else in your family blood-line had pancreatic cancer?
If so, what is their relationship to you (aunt, cousin, grandpa)?
Which side of the family (maternal, paternal)?

Have you ever had any genetic testing done for pancreatic cancer?
If so, what was the outcome?