Statement of Need for Pink Angel Fund Assistance

Pink Angel Fund Application

Name of Applicant: ____

Address: ____

Phone: ________________________Cell Phone_____________________

Email:_________________________ Physician (Optional)____________

Category of Need:____

I verify that I am currently undergoing medical treatment related to my diagnosis of breast cancer. I am requesting assistance to deal with the financial burden breast cancer has imposed on my life situation.

I understand that all information exchanged with the Pink Angel Fund of Westmoreland Walks, remains confidential with the Board of Directors and will not be shared with anyone else.

I am aware that once my need is reviewed and approved by the Pink Angel Committee, any monies given to me through Westmoreland Walks' Pink Angel Fund will be **given directly to a creditor or care-providing agent** I've designated. Examples where awards may be approved include but are not limited to treatment facilities, utility services, landlords, grocers, fuel cards, etc. Other needs will be considered by the Pink Angel Fund Committee as warranted by my diagnosis and/or need.

In compliance with Westmoreland Walks' visions for disbursement of monies, I acknowledge that I can apply for a diagnosis-related need **once per calendar year**. Upon receipt of monies from Westmoreland Walks' Pink Angel Fund, I will provide receipts from my creditors for accounting and auditing purposes.

Signature of Applicant_________________________________Date______________

For Westmoreland Walks Use Only:

PAF Committee Review Date/s_____________BOD Approval Date______________

Applicant Notification Date____