project purple
— A WORLD WITHOUT PANCREATIC CANCER —

nutre meal plans

Nutrition Assistance Program Form

Only patients, their spouse or child, a P.O.A., or a patient navigator or social worker at the treatment center may complete this form. Applications from others will not be accepted. Patients must have an email, computer access, and are responsible for ordering meals weekly; **Project Purple will not be responsible for ordering meals.** Please submit all documents in PDF format. Contact us with any questions. **Zina@projectpurple.org.**

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):

Date of Birth (MM/DD/YYYY):

Best Contact Number:

Best Email Address:

If you are NOT the patient, please complete the following:

Your Full Name: _____

Your Relationship to Patient (include P.O.A. proof if applicable):

Your Best Contact Number:

Your Email Address:

You MUST include the following documents with your application:

- ❑ A letter from your oncologist on official letterhead.
- ❑ Total Household Income - copy of previous year's signed 1040 tax return forms or a Supplemental Security Benefits letter *(SS, retirement, disability, and pension documents not accepted)* -- SNAP Award Letter *(if applicable)*
- ❑ Copy of Photo ID *(front and back)*

Please refer to the Nutrition Program Reference Guide for more detailed information about the required documents listed above.

List all members living in the household (please note how many are minors):

Living Arrangement (check one):

☐ Renting ☐ Own Home

☐ Other: _____

Have you received financial aid from another organization?

☐ No ☐ Yes — From whom? _____

Amount received: $_____

How did you find the Project Purple Nutrition Assistance program?

Have you received nutrition assistance from any other group/organization?

☐ No ☐ Yes — From whom? _____

Amount received: $_____

Additional Information (Optional, 300 words max):

Please check one:

☐ I **give permission** for Project Purple to use my application data (anonymously) for statistics.

☐ I **do not give permission** for my application data to be used.

I certify that all information provided is true and accurate. I understand that false information may result in denial of aid.

_____ _____

Signature of Patient Date

_____ _____

Signature of Person Filling Out Form Date

PANCREATIC CANCER QUESTIONNAIRE FORM

(Optional – Responses will not affect eligibility or awards granted)

This form is used solely for gathering anonymous data to support statistical research, increase scientific understanding, and raise public awareness about pancreatic cancer.

Personal Information

Gender at Birth: ☐ Male ☐ Female

Age at Time of Pancreatic Cancer Diagnosis: _____

Ethnicity: _____

Religion: _____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partnership ☐ Other: _____

Military Service

Did you serve in the military? ☐ Yes ☐ No

If yes, please specify:

- **Deployment Location(s):** _____
- **Dates of Service:** _____

  Are you a veteran? ☐ Yes ☐ No

Lifestyle & Habits

State/Region/Country where you have lived most of your life: _____

Physical Activity:

How many times per week do you exercise for 20 minutes or more? _____ times/week

Tobacco Use:

Do you currently smoke? ☐ Yes ☐ No

If yes, are you a:

☐ Social Smoker ☐ Regular Smoker

Average number of packs smoked per month: _____

Alcohol Consumption:

Do you drink alcohol? ☐ Yes ☐ No

If yes, how many drinks (glasses/beers) do you consume on average per month? _____

Recreational Drug Use:

Do you use recreational drugs? ☐ Yes ☐ No

If yes:

- **Primary drug of choice:** _____
- **How often do you use it?** _____

Medical & Family History

Family History of Pancreatic Cancer:

Has anyone in your biological family had pancreatic cancer? ☐ Yes ☐ No

If yes:

- Relationship (e.g., aunt, cousin, grandfather): _____
- Side of family: ☐ Maternal ☐ Paternal

Genetic Testing for Pancreatic Cancer:

Have you undergone genetic testing? ☐ Yes ☐ No

If yes, what were the results? _____

Treatment Information

Have you experienced any drug shortages related to your pancreatic cancer treatment?

☐ Yes ☐ No

If yes:

- **Which drug(s)? _____**
- **When did the shortage occur? _____**
- **How long did it last? _____**
- **How was it resolved? _____**