Emergency Financial Assistance Application Packet

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Dear Social Worker or Health Care Professional,

Angel Foundation requires that an applicant work with a social worker or health care professional to help them complete our application for emergency financial assistance. The health care professional or social worker will also serve as our main contact if questions arise regarding the patient's application.

Here is an overview of Angel Foundation's procedures. Please contact us if you have any questions or concerns.

Angel Foundation Procedures:

1. The Medical Information Form and top portion of the Patient Information form needs to be completed by a social worker or health care professional. An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to verify the patient has cancer and is currently undergoing treatment by signing the Medical Information Form. Medical records do not need to be sent.

2. The Patient Information Form and Release Form need to be completed by the patient, including the patient's signature.

3. Please mail or fax the completed paperwork to the address/fax number listed on the cover page. Once the application has been processed, Angel Foundation will contact the patient, social worker or health care professional via mail or email to inform them of the grant details.

4. All three pages of the application must be completed in order to be processed. Incomplete applications will be returned for completion and will not be reviewed until a completed application is submitted.

5. Upon receipt of the approval letter, the patient is required to complete the Bill Payment Form, submit copies of all bills to be paid, and/or indicate if gift cards are requested. Bills must be in the patient or spouse's name, or the patient must prove payment history. Please note all checks will be made payable to the vendor (e.g., Xcel Energy, Qwest) and will be sent directly to the patient to submit.

GENERAL GRANT GUIDELINES AND CRITERIA FOR FUNDING

General Grant Requirements

- Patient must be living in, or treated in, the seven county metro area of Minnesota. The counties include Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington.
- Patient must be 18 years or older.
- Patient must have a cancer diagnosis and be in active treatment.
    - Active treatment includes chemotherapy, radiation, bone marrow transplant, hospice or palliative care and surgery when the recovery period is in excess of 4 weeks.
    - Active treatment does not include hormone therapy.
- Patient must meet financial guidelines set by Angel Foundation.
- Patient is able to receive one general grant through Angel Foundation.

Application Requirements

- The Medical Information Form and top portion of the Patient Information Form must be completed by a social worker or health care professional.
- An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to sign the Medical Information Form to confirm the cancer diagnosis.
- The Release Form must be signed by the patient.

Eligible Requests

- Angel Foundation approves requests for basic living expenses such as rent or mortgage, food, gas and utilities.
- If approved for a grant, copies of all eligible bills to be paid must be submitted to Angel Foundation.
- If requesting assistance with rent, a copy of the first page of the lease or a letter from the landlord is required.

Ineligible Requests

- Angel Foundation does not approve requests for payment of medical bills, prescriptions, or alternative medicines/therapies.
- Angel Foundation does not approve requests for payment on bills other than rent, mortgage, food, gas or utilities.

Administration

- Checks will be made payable to vendors and returned to the patient to submit.
- Checks will not be made payable directly to patients.
- If approved, the grant expires after 90 days.

MEDICAL INFORMATION FORM
TO BE FILLED OUT BY HEALTH CARE PROFESSIONAL

Patient Information: Date: __________________

First Name: ___________________________ Last Name: ____

Date of Birth: ____________________ Gender: M ___ F ____ Veteran: Yes ________ No __________

Racial/Ethnic Identity: __________________ Marital Status: _____________________________________
(I.e. single, married, divorced, widowed)

Diagnosis:_______________________ Stage: _________ Date of Diagnosis: ______________________

Current Treatment (Check all that apply)

______ Chemotherapy Date of Last Treatment: ____________________

______ Radiation Date of Last Treatment: ____________________

______ Bone Marrow Transplant Date of Last Treatment: ____________________

______ Surgery Date of Last Surgery: ______________________

______ Palliative Care Date Entered: _____________________________

______ Hospice Date Entered: _____________________________

TO BE SIGNED BY TREATING ONCOLOGIST, REGISTERED ONCOLOGY NURSE
OR LICENSED MEDICAL SOCIAL WORKER
I attest the patient has cancer and is currently being treated as stated above

X____

Clinic Information:

Clinic:____________________________________ Oncologist: ______________________________

Address: ____ City: _________________________

State:_____________ Zip:____________________ Phone: (_____) ________-__________

Social Worker/ Health Care Professional Information:

Name:____ Phone: (____) _______-___________

Clinic/ Organization: ____

Address: ____

City: ___________________ State: ________ Zip: _________ Fax: (_____) _______-_____________

Email: ____

*Information regarding the qualifying amount for this patient will be sent to you via email

PATIENT INFORMATION FORM

Social Worker/Health Care Professional: Please inform us why the patient is in need of Emergency Financial Assistance (REQUIRED):

____
____
____

Patient Information

First Name: ___________________ Last Name:__________________________________

Address: ___________________________________ City: _________________________

State:______ Zip:_______ County:________________ Phone:____________________

Email:____

Is okay to leave a message on your phone? ☐ Yes ☐ No

Inform me regarding my application via ____Email or ____ Mail

Responsible Party (If different than above)

First Name: ___________________ Last Name:_________________________________

Address: __________________________________ City: _________________________

State:______ Zip:_______ County:________________ Phone:___________________

Email:____________________________ Relationship to patient:_________________

Please list the people in your household

Name	Date of Birth	Relationship

Financial Information

Total Monthly Household Income (After Taxes):_____________________________

Estimated Household Assets (Do Not Include Retirement Accounts):

Checking:______________ Savings/CD:______________ Stocks:______________

Savings Bonds:_________Money Market_____________ Other:_______________

Total Estimated Household Assets:____

PATIENT RELEASE FORM

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Angel Foundation. I hereby give my permission that this application and all information provided can be sent to Angel Foundation and discussed with my health care professional. All information reviewed is confidential.

Patient Signature:_________________________________ Date:___________

Print Name:____

Please take some time to answer the questions below

I would like to be on Angel Foundation's mailing list? ☐ Yes ☐ No

How did you hear about Angel Foundation?

_________ Social Worker Name: ____________________________________
_________ Nurse Name: __________________________________
_________ Oncologist
_________ Patient Financial Counselor
_________ Patient Navigator
_________ Friend Name:___________________________________
_________ Internet
_________ Brochure
_________ Other:____

Please provide additional comments regarding your situation that might be helpful when reviewing your application.

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