FINANCIAL SERVICES

One Application Packet for:

- Emergency Financial Assistance Grant
- Financial Cancer Care Program

or

- Apply for both at the same time

**Please note your application may take 5-7 business days to process.**
Program Requirements

Emergency Financial Assistance (EFA) Grant

EFA supports adult cancer patients by relieving some of their immediate financial concerns. These financial grants help with basic, non-medical bills such as rent, mortgage, utilities, food, and fuel.

- Patient must meet financial guidelines set by Angel Foundation.
- Patient may receive one General Assistance Grant per lifetime.
- Grant funds may be used only for housing (rent/mortgage), utilities, Cub Foods gift cards or Holiday gas gift cards. Funds cannot be used for medical bills, prescriptions, insurance payments or any other type of bill.
- Checks are made payable to the vendor and returned to the patient to submit. Checks are not made payable to the patient.
- Grant expires after 90 days.

Financial Cancer Care (FCC) Program

Financial Cancer Care helps patients manage the long-term financial burdens of a cancer diagnosis by connecting patients to Certified Financial Planners™ to create a financial plan.

- Patient must be financially independent.
- Not currently working with a Financial Planner.

Both Programs

- Patient must be 18 years of age or older.
- Patient must have a cancer diagnosis and be in active cancer treatment.
- Patient must be living in – or receiving cancer treatment in – the seven-county metro area of Minneapolis/St Paul (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington counties).
- Active treatment includes one or more of the following:
  
  **Both EFA and FCC:**
  - o  Chemotherapy
  - o  Radiation
  - o  Bone marrow transplant
  - o  Surgery when the recovery period is more than four weeks
  
  **EFA Only:**
  - o  Hospice or palliative care
  
  **FCC Only:**
  - o  Hormone Therapy
  - o  Immunotherapy
Application Requirements

• The patient provides information for Patient, Medical, Household and Financial sections and signs the application.
  o NOTE: It may be helpful to have financial information handy for completing application questions, such as total monthly household income (after taxes) and current balances for checking, savings and other accounts.

• The oncology social worker or oncology health care professional completes and signs the Medical Information section.

Patient Information

☐ I am the patient, applying for myself.
☐ I am assisting the patient; my relationship to the patient is ________________________________.
☐ I am an oncology health care professional assisting the patient.

If applying for the Emergency Financial Assistance grant, please tell us why you are in need of Emergency Financial Assistance.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

If applying for the Financial Cancer Care Program, please tell us why you are interested in working with a Certified Financial Planner™.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

First Name ______________________ Middle Initial ______ Last Name ________________________________
Birthdate (MM/DD/YYYY) ___________________________ County ________________________________
Street Address _____________________________________________________________________________
City _____________________________ State ___________ Zip ______________ 
Phone __________________________________ Email __________________________________

May we leave a message on your phone?
☐ Yes
☐ No
Will you need language translation?
  □ Yes  [Language:______________________________]
  □ No

Inform me regarding my application via:
  □ Mail to my address
  □ Both email and mail

May we discuss your application with anyone besides your health care team?
  □ Yes  [Please list name(s)______________________________]
  □ No

Employer__________________________________________

Medical Insurance Provider__________________________________________

Gender:
  □ Female
  □ Male
  □ Prefer not to answer

Ethnicity:
  □ African
  □ Asian
  □ Black/African-American
  □ Caucasian
  □ Hispanic/Latino
  □ Middle Eastern
  □ Native American
  □ Other__________________________________________
  □ Prefer not to answer

Marital Status:
  □ Single
  □ Married
  □ Partnered
  □ Separated
  □ Divorced
  □ Widowed

United States Military Veteran:
  □ Yes
  □ No
Medical Information

Type of Cancer Diagnosis__________________________________ Stage______

Clinic/Hospital Name______________________________________ City__________

Clinic/Hospital Phone__________________________Oncologist’s Name________________________

Household Information

Please list the other people in your household.

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<tr>
<th>Name</th>
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What is your housing situation?

□ Stable

□ Unstable

□ Homeless

□ Prefer not to answer

Financial Information

Total Monthly Household Income (after taxes)     $____________________

Estimated Household Assets (do not include retirement accounts):

Checking     $____________________

Savings/CD    $__________________

Other         $__________________

TOTAL ASSETS $__________________

Add any other comments:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Patient Release

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

______________________________________________________________________________

Signature

Date

Additional Information

How did you hear about Angel Foundation?

☐ Social Worker
☐ Patient Navigator or Counselor
☐ Nurse
☐ Doctor
☐ Friend or Relative
☐ Internet
☐ Other ________________________________

May we add you to our mailing list?

☐ Yes
☐ No

Would you be willing to share your story with our community?

☐ Yes  [This is not required to receive assistance. If you choose yes, someone from Angel Foundation may contact you.]
☐ No
Medical Information

(This page is to be completed by an oncology health care professional.)

Patient Information

First Name__________________________Middle Initial _______Last Name ____________________________

Birthdate (MM/DD/YYYY)____________________County______________________________

Street Address____________________________________________________________

City________________________________________State_________________Zip________________

Phone____________________________Email______________________________

Medical Information

Type of Cancer Diagnosis________________________________________Stage________

Current Treatment (please check all that apply):

☐ Chemotherapy Date of last (or next) treatment______________________________

☐ Radiation Date of last (or next) treatment______________________________

☐ Bone Marrow Transplant Date of transplant______________________________

☐ Surgery Date of surgery______________________________________________

Will the patient’s recovery from surgery take at least four weeks?

☐ Yes

☐ No

☐ (EFA ONLY) Palliative Care  Date entered_____________________________________

☐ (EFA ONLY) Hospice  Date entered_____________________________________

☐ (FCC ONLY) Hormone Therapy  Date of last (or next) treatment____________________

☐ (FCC ONLY) Immunotherapy  Date of last (or next) treatment____________________

Clinic Information

Clinic Name________________________________________County______________________

Street Address____________________________________________________________

City________________________________________State_________________Zip________________

Oncologist______________________________________________________________

I attest the patient has cancer and is currently being treated as stated above.

_________________________________________  __________________________________________

Name (please print)  Title

_________________________________________  __________________________________________

Signature  Date