Help when cancer strikes

angel foundation

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.

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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:

  - Chemotherapy
  - Radiation
  - Bone marrow transplant
  - Surgery when the recovery period is more than four weeks

  EFA Only:

  - Hospice or palliative care

  FCC Only:

  - Hormone Therapy
  - Immunotherapy

Application Requirements

- The patient provides information for Patient, Medical, Household and Financial sections and signs the application.
    - 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.

Name	Date of Birth	Relationship

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