Help when cancer strikes

angel foundation

One Application Packet for:

- ☑ **Emergency Financial Assistance Grant**
- ☑ **Financial Cancer Care Program**
- ☑ **Apply for Both** at the same time

*** Please note your application may take 5–7 business days to process. ****

Application Requirements

- The patient provides information for Patient, Demographic, Medical, Household, Financial and Additional Information sections and signs the application.
- A member of your oncology care team completes and signs the Medical Information section.

COMPLETE APPLICATION USING PEN OR COMPUTER

- Complete printed copy and return in-person or via mail to:
  Angel Foundation
  1155 Centre Pointe Dr., Ste. 7
  Mendota Heights, MN 55120
- Fill out form electronically, selecting **"Save"** periodically as you work and once completed. Return pdf via email to **grants@mnangel.org**

FINANCIAL SERVICES

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 needs.

- Patient is in active treatment for cancer.
- Patient meets financial guidelines set by Angel Foundation.
- Patient may receive one General Assistance Grant.
- Grant funds may be used only for housing (rent/mortgage), utilities, Cub Foods gift cards or Holiday gas gift cards.
- 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 has received treatment for cancer within the last 12 months.
- Patient is financially independent.
- Patient is not currently working with a Financial Planner.

Both Programs

- Patient is 18 years of age or older.
- Patient has a cancer diagnosis.
- Patient is in active treatment for cancer.
- Cancer diagnosis and treatment are verified by a health care professional on Medical Form.
- Patient is living in— **or** receiving cancer treatment in— the seven-county metro area of Minneapolis/St. Paul: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, Washington counties.
- Treatment includes one or more of the following for both EFA and FCC programs, identified by doctor as **active cancer treatment**:
  - Chemotherapy
  - Radiation
  - Immunotherapy
  - Hormone therapy
  - Bone marrow transplant
  - Surgery with recovery period of more than four weeks
  - Palliative care
  - Hospice
  - Other treatment per doctor

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.

I am applying for: [ ] EFA Grant [ ] FCC Program [ ] Both EFA and FCC

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 _____ Apt _____

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 _____

_____

Demographic Information

Gender:

- ☐ Female
- ☐ Male
- ☐ Prefer to self-describe

  _____
- ☐ Prefer not to answer

United States Military Veteran:

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

Ethnicity: (please check all that apply)

- ☐ African
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Caucasian
- ☐ Hispanic
- ☐ Latino/a/x
- ☐ Middle Eastern
- ☐ Prefer to self-describe

  _____
- ☐ Prefer not to answer

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Partnered
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Prefer not to answer

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 (MM/DD/YYYY)	Relationship
_____	/ /	_____
_____	/ /	_____
_____	/ /	_____
_____	/ /	_____
_____	/ /	_____

What is your housing situation?

☐ Stable ☐ Homeless ☐ Unstable ☐ 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	$ _____

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

Please list anything else you would like us to know.

Important

Part of the application process includes the completion of the **Medical Information Form** by a member of your oncology treatment team. This individual may be a social worker, nurse, navigator or doctor. The Medical Information Form may be downloaded from our website at **mnangel.org/financialassistance**.