Financial Relief and Assistance Application

If you are in need due to the effects of cancer, Daniel's Grace encourages you to apply for financial assistance or relief. Please provide as much information as you can in order for us to best assess each situation. If you have questions or need help completing this application, please email helpinghands@danielsgrace.org.

Incomplete applications will be returned without consideration

SECTION A: PERSONAL INFORMATION: (Please print clearly)

Today's Date: ______________________

Applicant's Name: ___________________________ Social Security Number: _____________________________

Spouse's Name: _____________________________ Social Security Number: _____________________________

Head of House Hold's Name: ____________________ Marital Status: ( ) Married ( ) Separated ( ) Divorced ( ) Single

Address: _____________________________________ City, State, Zip:____________________________________

Phone Number: ______________________________Email Address: _______________________________________

Person in your family with cancer diagnosis: ____

Is your family covered by Insurance? ( ) Yes ( ) No

Type of Cancer: ___________________________ They are currently: ( ) In Treatment ( ) In Remission ( ) Deceased*

** If the member of your household is deceased please skip to SECTION C**

Please list below the people in your household. List the dollar amount of the total monthly income that supports the household. Include money that is earned (paychecks, profits, interest, savings) as well as income that in not earned (welfare, unemployment, child support, gifts, grants). INCLUDE YOURSELF.

Name	Birth Date	Relationship	Monthly Income
1			
2			
3			
4			
5			
6			

SECTION B: MEDICAL INFORMATION:

**** This section must be completed by your Oncology Nurse, Doctor, or Social Worker Only****

Date of Diagnosis: _____________________ Primary Cancer: ____

Current Stage: ___________________________ This is a: ( ) New Diagnosis ( ) Recurrence

Is this Patient in active Treatment: ( ) Yes ( ) No

If not in active treatment, indicate frequency of follow-up: ( ) Yearly ( ) Every six months

( ) Other: ____

Please indicate type of treatment(s) received in the past twelve months (check all that apply)

( ) Chemotherapy ( ) Radiation ( ) Surgery ( ) Hormonal ( ) Palliative care ( ) Bone marrow/ stem cell transplant

Health Care Professional Information (please print)

MD Name: ______________________________ Hospital/Clinic: ______________________________________

Address: _____________________________________ City, State, Zip:_________________________________

Phone Number: ______________________________Fax number: ____________________________________

Email Address: ______________________________________

Your relationship to person applying for help: ( ) Doctor ( ) Nurse ( ) Social Worker

____

Signature / Date of MEDICAL Professional:

SECTION C: FINANCIAL INFORMATION: Please be aware that funds are limited and based on availability.

Is the patient currently employed? : ( ) Yes ( ) No
Family Income Sources (Please check all that apply)
( ) Salary ( ) Social Security ( ) Pension ( ) Unemployment ( ) Public Assistance ( ) Short- Term disability
( ) SSD (Disability) ( ) SSI – Supplemental Security Income ( ) Veteran's/Military Benefits ( ) Workman's Compensation ( ) Family/ friends provide support ( ) Other____

Net Monthly Income: Please indicate all sources of income.
Patient: $_____________________
Applicant (if not patient): $_____________________
Spouse / Significant other: $_____________________
Non-profit charity / assistance: $_____________________
Other Income: $_____________________(SSI, SSDI, SNAP, CHILD / SPOUSAL SUPPORT)

TOTAL NET MONTHLY INCOME $____________________

Current Average monthly expenses: **Please provide copies of bills / invoice**

Food: $_____________________
Utilities: $_____________________
Vehicle Gas: $_____________________
Telephone: $_____________________
Child / Dependent care: $_____________________
Court-Ordered Payments: $_____________________ (Child/Spousal Support, Liens,Judgements,Insurance)
Other: $_____________________
Other: $_____________________

Creditors (Monthly):
Rent/Mortgage: $_____________________ Creditor name____________________
Automobile payment: $_____________________ Creditor name____________________
Insurance (auto): $_____________________ Creditor name____________________
Insurance (other): $____________________ Creditor name____________________
All Credit Card (s): $_____________________ Creditor name____________________
Other monthly payment: $_____________________ Creditor name____________________

TOTAL MONTHLY EXPENSES: $____________________

RENT / MORTGAGE INFORMATION: (Please provide copies of lease OR mortgage statement and the following information):
Name of Landlord or Mortgage Company: ____
Payment Address: ____ Account Number: ______________________
City: ___________________________ State: _____ Zip: ___________
Your Property Address: ______________________________________
City: ___________________________ State: ____ Zip: ___________

WHAT IS CURRENTLY YOUR GREATEST FINANCIAL NEED? ____
____
____

SECTION D: YOUR STORY – *please provide a written letter telling us your story. Include specifics of what assistance will best help you and your family.*

SECTION E:

I, _________________________, certify that all the information listed above is accurate and complete to the best of my knowledge.

(Print Name) ___________________________________

Signature: ___________________________________ Date: ____________________

APPLICATION CHECKLIST – Must include the following:

Incomplete applications will be returned without consideration.

1. **Signed application (by both the patient and medical representative)**
2. **Copies of all income sources**
3. **Copies of all bill / creditor statements (must include account numbers and mailing address for creditor.)**
4. **Written letter telling your story**

Please remit this completed form to:

Daniel's Grace 4216 Virginia Beach Blvd, Suite 140, Virginia Beach, VA 23452 or to Helpinghands@DanielsGrace.org

(Disbursement of assistance can take up to 45 days)