



CHARITABLE FOUNDATION

Financial Relief and Assistance Application

If you are in need due to the affects 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: _____ Head of House Hold's Name: _____
Spouse's Name: _____ Marital Status: () Married () Separated () Divorced () Single Parent
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).

Table with 4 columns: Name, Birth Date, Relationship, Monthly Income. Rows 1-6.

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: \$ _____

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, health insurance...):
\$ _____
Other: \$ _____
Other: \$ _____

Creditors

Rent/Mortgage:	\$ _____	Creditor name _____
Automobile loan:	\$ _____	Creditor name _____
Insurance (auto):	\$ _____	Creditor name _____
Insurance (other):	\$ _____	Creditor name _____
Other Payment:	\$ _____	Creditor name _____
Other Payment:	\$ _____	Creditor name _____

TOTAL MONTHLY EXPENSES: \$ _____

FEDERAL TAX INFO: Provide a copy of your most recent Federal Tax Return

Did you file federal income taxes? () Yes () No
Do you plan to file federal income taxes next year? () Yes () No
If you plan to file federal income tax, will you file jointly with a spouse? () Yes () No
If yes, please list spouse’s name: _____
If filing, will you claim any dependents on your tax return? () Yes () No
If yes – please list names: _____
If you do NOT plan to file, will you be claimed as a dependent on someone’s tax return? () Yes () No
If you, please list name of person claiming you as a dependent: _____

Do you owe any past due Federal or State taxes? () Yes () No

****provide a copy of your most recent Federal Tax Return****

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
2. Copies of all income sources
3. Copies of all bill / creditor statements
4. Copy of most recent Federal Tax Return
5. 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)