Daniel's Grace
CHARITABLE FOUNDATION

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.

ALL APPLICATIONS MUST BE SUBMITTED BY YOUR NURSE NAVIGATOR OR SOCIAL WORKER

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

Please list below the people in your household (INCLUDE YOURSELF). 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).

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

SECTION B: MEDICAL INFORMATION:

**** This section must be completed by your Nurse Navigator 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: _____

( ) Nurse Navigator ( ) Social Worker Name:

_____

Phone Number: _____Fax number: _____

Email Address: _____

_____

Signature / Date of Nurse Navigator / Social Worker

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 _____
Have you applied for SSI or SSD? ( ) Yes ( ) No
If Yes, What date applied? _____ If No, state reason? _____
Net Monthly Income: Please provide CURRENT copies of all sources of income.
Patient: $_____
Applicant (if not patient): $_____
Spouse / Significant other: $_____
Other Income: $_____

TOTAL NET MONTHLY INCOME $_____

Current Average monthly expenses:
****Please provide CURRENT copies of bills / invoice for all dollar amounts listed below****
*****Please include last four digits of your social security number for financial assistance and identifying patient accounts_____.**

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: $_____

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: APPLICANT SIGNATURE
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 not be considered

1. **Signed application**
2. **Copies of all income sources**
3. **Copies of all current bills / creditor statements**
4. **Copies of most current bank statements – 3 months**
5. **Written letter telling your story – explain your specific need that will help you/your family most**
6. **Submitted through your Nurse Navigator / Social Worker**

Nurse Navigators / Social Workers, please submit this completed form to:
Daniel's Grace 4216 Virginia Beach Blvd, Suite 140, Virginia Beach, VA 23452 or to
Helpinghands@DanielsGrace.org

NURSE NAVIGATOR / SOCIAL WORKER – SPECIAL NOTES SECTION / ADDITIONAL INFORMATION