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****

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: 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. **Copy of most recent Federal Tax Return**
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