



# Relief Program

[www.NeedsBeyondMedicine.org](http://www.NeedsBeyondMedicine.org)

## **NEEDS BEYOND MEDICINE MISSION STATEMENT**

*Needs Beyond Medicine is a nonprofit organization whose mission is to decrease the burden of cancer by increasing awareness, education, and relief to cancer patients. Needs Beyond Medicine's primary focus is to offer assistance by enhancing the quality of life for those diagnosed with cancer through educational and financial support.*

## **NEEDS BEYOND MEDICINE: RELIEF PROGRAM GOAL**

Needs Beyond Medicine's *Relief Program* creates a financial assistance grants for cancer patients. These grants can be used to supplement living expenses not classified as a medical expense. Examples of such living expenses include rent, utilities, groceries, transportation costs, and more. These grants help provide much needed relief for adults facing extreme hardships during the greatest fight of their lives.

## **NEEDS BEYOND MEDICINE: RELIEF PROGRAM GUIDELINES**

Prior to applying for a grant through the Needs Beyond Medicine's *Relief Program*, all other financial options must be exhausted. *Relief Program* funding is used to help cover living expenses that cannot be met through a medical insurance plan or other financial assistance programs within the community. The maximum annual award is \$250.00 per individual/household. Individuals may only apply once per calendar year. Needs Beyond Medicine will evaluate all applications on a monthly basis. The number of awards dispensed each month may vary depending on the current amount of funds available.

The *Relief Program* is able to assist those in need by receipt of a grant from American Express and community donors.

# Needs Beyond Medicine: *Relief Program*

Awareness. Education. *Relief*

## **Relief Program Application**

Applicant Information: Fill Out Completely

(Please make sure to give us your current address, where the check can be mailed)

**Needs Beyond Medicine will not cover the costs of medical expenses.**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Date of Birth \_\_\_\_\_

Best method and time to contact you \_\_\_\_\_

Type of cancer \_\_\_\_\_ Stage of cancer \_\_\_\_\_

Date diagnosed with cancer \_\_\_\_\_ Name of doctor \_\_\_\_\_

Type of treatment you are going through \_\_\_\_\_

Currently in treatment? YES NO Date treatment began \_\_\_\_\_

Receiving treatment where? \_\_\_\_\_

Length of treatment \_\_\_\_\_

Previously applied for money from NBM? YES NO If yes, date received \_\_\_\_\_

**Please enter the dollar amount requested for the following non-medical expenses and give specific details on the line below (must add up to \$250):**

- Transportation: \$ \_\_\_\_\_  
**Explain:** \_\_\_\_\_
- Utilities: \$ \_\_\_\_\_  
**Explain:** \_\_\_\_\_
- Groceries: \$ \_\_\_\_\_  
**Explain:** \_\_\_\_\_
- Personal Supplies: \$ \_\_\_\_\_  
**Explain:** \_\_\_\_\_
- Recovery Items: \$ \_\_\_\_\_  
**Explain:** \_\_\_\_\_
- Other (Specify): \_\_\_\_\_

What other financial resources have you tried? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Relief Program (Continued)**

**Applicant Information:**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_

**Race/Ethnicity:**

African American  Asian  Native American/ Alaskan  
 Pacific Islander  Caucasian  Hispanic  Other

Gender:  Female  Male

Number of people in household \_\_\_\_\_

**Annual Family Income:**

Less than 10,000  10,000- 14,900  15,000-24,900  25,000-34,900  
 35,000 – 44,900  45,000-54,900  55,000-64,900  65,000+

Do you have insurance?  Yes  No  
If yes, what is the name of your insurance company? \_\_\_\_\_

How did you hear about Needs Beyond Medicine? \_\_\_\_\_  
Person and/or health care office who referred you \_\_\_\_\_  
Phone \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

**Application void without applicant's signature**

Information supplied through this application will be kept confidential and will only be used by Needs Beyond Medicine for grant evaluation purposes. If any additional information is needed for a selection to be made, we will contact you.

**To submit application mail to:  
Needs Beyond Medicine  
PO Box 521618  
Salt Lake City, UT 84152-1618**

***Information submitted with this application will be kept confidential and will only be used by Needs Beyond Medicine for reporting purposes.***

**Office Use Only**

Date Received \_\_\_\_\_ Approved \_\_\_\_\_ Applicant Contacted \_\_\_\_\_