Relief Program

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 _____