Relief Program Application

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 assist in 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* provides financial assistance grants for cancer patients. These grants are designed to supplement non-medical living expenses including rent, utilities, groceries, and transportation costs. These grants help provide much needed relief for adults facing extreme hardships during the greatest fight of their lives.

NEEDS BEYOND MEDICINE: *REVIEW TIMELINE*

Needs Beyond Medicine reviews the applications the first week of each month. The approval, or denial, of an application will be provided to the applicant within 14 days of the beginning of each month. Based on the amount of applications, or if an application is received after the first of the month, it may be reviewed the following month for consideration.

The *Relief Program* is able to assist those in need by the continuing support of our community partners and the receipt of a grant by

Needs Beyond Medicine: *Relief Program*

Awareness. Education. *Relief*

***Relief Program* Application**

Please fill out the application completely otherwise the application cannot be considered. Be sure to include your current address where the funds can be mailed.
Please write legibly, as the application may not be approved if information cannot be reviewed.
Needs Beyond Medicine will not cover the costs of medical expenses.

Name_____ Phone Number_____

Address_____

City_____ State_____ Zip_____

Email_____

Date of Birth_____

Best time to contact you ____Morning ____ Afternoon _____ Evening

Type of cancer_____ Stage of cancer_____ Date diagnosed_____

Name of doctor_____ Relapse of Cancer ____ Yes ___ No

Type of treatment you are going through _____

Are you currently receiving treatment? YES NO Date treatment began_____

Where are you receiving treatment?_____

Length of treatment (estimate if possible) _____

Other resources you have tried (check all that apply): ____ Family ___ Church ____ Local Charity
____ Hospital receiving treatment ____ National Charity Other_____

-Continue-

*Relief Program (*Continued)

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: $_____
Details: _____
Utilities: $_____
Details: _____
Groceries: $_____
Details: _____
Personal Supplies: $_____
Details: _____
Recovery Items: $_____
Details: _____
Other (Specify): _____

Applicant Information:

Race/Ethnicity:

_____ African American _____ Asian _____ Native American/ Alaskan _____ Pacific Islander

_____ Caucasian _____ Hispanic/Latino _____ Other Specify _____

Gender: ____ Female ____ Male

Military Status: _____ Not a Veteran _____ Veteran _____Disabled Veteran ____Vietnam-Era Veteran

____Special Disabled Veteran ____Other Protected Veteran ____Newly/Recently Separated Veteran

____ Armed Forces Service Medal Veteran

Number of people in household _____ Adults ____ Children

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? _____

-Continue-

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

Completed applications should be mailed to:
Needs Beyond Medicine
PO Box 521618
Salt Lake City, UT 84152-1618

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

Office Use Only
Date Received _____ Approved _____ Applicant Contacted _____