Relief Program Application

RELIEF PROGRAM GOAL

Needs Beyond Medicine's Relief Program provides financial assistance grants for adult cancer patients. These grants are designed to supplement non-medical living expenses such as rent, utilities, groceries, transportation costs, etc. These grants help provide much needed relief for adults facing extreme hardships during the greatest fight of their lives.
The primary goal is to provide grants of $250 to Utahns battling cancer. Alleviating the stress of decreased income can improve quality of life and medical outcomes for grant recipients.

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 the following month application is received. 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. All applications not completely filled out will be voided immediately with no review. All applicants will be notified on being awarded or denied.

MISSION STATEMENT

Needs Beyond Medicine is dedicated to helping cancer patients pay for non-medical expenses while undergoing medical treatment. Our mission is to decrease the burden of cancer by increasing awareness, education, and relief to cancer patients.
Needs Beyond Medicine is focused in an effort to offer assistance toward enhancing the quality of life for those diagnosed with cancer through educational and financial support.

The Relief Program is able to assist those in need by the continuing support from our donors, community partners, and grants.

Needs Beyond Medicine: Relief Program

Please fill out the application completely and legibly otherwise the application cannot be considered. Be sure to include your current address where the funds 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____________________

Type of cancer___________________ Stage of cancer_______ Date diagnosed_____________

Name of doctor_____________________
Relapse of Cancer: Yes _____ No _____
Date/Type Of Diagnosis ____

Type of treatment you are going through (Specific) ____

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-

Previously applied for assistance 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:

Are you active duty or retired military? Yes______ No_____

If so, are you eligible for VA Benefits? Yes_______ No______

Number of people in household: Adults ____ Children ______

Annual Household 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+

-Continue-

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 is 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 _________

Denial Reason ____