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 applications during the first week of each month. The approval or denial of an application will be provided to the applicant within the first 15 days of the following month in which the application is received. Based on the number of applications received, or if an application is received after the first of the month, it may be reviewed the next month instead. All applications that are not completely filled out will be voided immediately with no review.
<u>All applicants will be notified whether being awarded or denied.</u>

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 on assisting those diagnosed with cancer and enhancing their quality of life 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

Fill out the application completely and legibly otherwise the application will not be considered. Include your current mailing 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____________________________

Previously applied for assistance from NBM? Yes ____ No____ If yes, date received_____________

What makes you or your situation unique from other applicants applying for this grant?

____

____

____

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:

1. Race/Ethnicity:

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

_____ Caucasian _____ Hispanic/Latino _____ Other Specify _________________________

2. Gender: Female ______ Male ______

3. Military Status:
Are you active duty or retired military? Yes_______ No_______

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

4. Employment Status:

_____ Employed, full time _____ Employed, part time _____ Unemployed _____ Self-employed

_____ Home-maker _____ Student _____ Disabled, not able to work

If applicable, employer: ______________________________________

5. Job title: ____

6. Marital Status: _____ Single _____ Married _____ Divorced _____ Separated _____ Widowed

7. Number of people in household: Adults_______ Children_______

8. 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+

9. Do you have insurance? Yes ______ No _______
If yes, what is the name of your insurance company? ____

10. How did you hear about Needs Beyond Medicine? ____

11. 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 712043
Salt Lake City, UT 84171

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 ____