RELIEF PROGRAM APPLICATION

Relief Program Goal

The primary goal of the Relief Program is to provide $500 grants to adult cancer patients in Utah. These grants are designed to supplement non-medical living expenses such as housing, utilities, groceries, transportation, etc. Alleviating the stress of decreased income can improve the quality of life and positively impact medical outcomes for grant recipients.

Our Mission

It is our mission to help 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 education and financial support.

PLEASE NOTE

Applications are reviewed 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 was received. Based on the number of applications submitted in a given month, or if an application I received after the first of the month, it may be reviewed the following month. Applications must be completed and legible or it will be voided immediately with no review. All applicants will be notified whether being awarded or denied a financial grant.

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

Personal Information

1. Full Name: ____
2. Address: ____
3. City, State, Zip: ____
4. Date of Birth: _____/_____/_________
5. Gender: ______________
6. Phone Number: ____
7. Email: ____
8. Marital Status:
   - __ Single (never married)
   - __ Married
   - __ Widowed
   - __ Separated
   - __ Divorced
9. Household size (including yourself, spouse, and all dependents): _________________________
10. How would you describe yourself?
    - __ American Indian or Alaska Native
    - __ Asian
    - __ Black
    - __ Caucasian (White)
    - __ Hispanic/Latinx/Spanish Origin
    - __ Native Hawaiian or Other Pacific Islander
    - __ Other (specify) _______________________

Financial-

WE WILL NOT COVER MEDICAL RELATED EXPENSES. YOUR APPLICATION MAY BE REVOKED IF YOU ASK FOR FINANCIAL ASSISTANCE FOR MEDICATION OR OTHER MEDICAL COSTS ASSOCIATED WITH TREATMENT.

11. Have you previously applied for Needs Beyond Medicine financial assistance? YES/NO

    If yes, month/year you applied: _____/________

12. What are you requesting financial assistance for? (Select all that apply)

    <u>$ Amount- Please include dollar amount next to each item</u>

    ________ Rent/ Mortgage

    ________ Transportation

    ________ Groceries

    ________ Utilities

    ________ Recovery Items

    ________ Other (please explain): ____

13. Employment status:

__ Full Time
__ Part Time
__ Self-employed
__ Unemployed
__ Unable to work
__ Homemaker
__ Student
__ Retired

14. If applicable, name of your employer: ____

15. Yearly household income:

__ $0
__ $1 to $9,999
__ $10,000 to $19,999
__ $20,000 to $34,999
__ $35,000 to $49,999
__ $50,000 to $74,999
__ $75,000 to $99,999
__ Over $100,000

16. Do you have medical insurance? YES / NO

    i) If yes, what is the name of your medical insurance provider? ________________________

17. Military Status:

    Are you active duty or retired military? YES / NO or N/A

    Are you eligible for VA Benefits? YES / NO or N/A

18. What other resources have you tried to get financial assistance through? Select all that apply.

__ Family
__ Church
__ Local Charity
__ Medical facility you're receiving treatment at
__ National Charity
__ Other ____

Medical

19. Type of cancer you have been diagnosed with: ____

20. Stage of cancer: ___________

21. Date diagnosed: _____/______/________ (**Most CURRENT diagnosis)**

22. Is this a relapse of cancer? YES / NO

    a. If Yes, Original Diagnosis Type & Date:

    ____

23. Name of your doctor: ____

24. Are you currently receiving treatment? YES / NO
    a. If NO, when will you start treatment: ________________________________
25. What type of treatment are you receiving? ________________________________
26. Date treatment began: _____/______/________
27. Length of treatment (estimate if possible): ________________________________
28. Medical facility where you receive treatment: ________________________________

Referrals

29. How did you hear about Needs Beyond Medicine? ____________________________
30. Did a person or medical office refer you to us? Please name: ______________________
31. Their Phone number: ____
32. Their Address: ____
33. City, State, Zip: ____

I hereby certify that all the information provided on this form is true and correct. I understand that providing false information leads to denial of my application.

Applicant Signature: ____________________________________ Date: ____________

APPLICATION IS VOID WITHOUT APPLICANT SIGNATURE.

COMPLETED APPLICATIONS SHOULD BE MAILED TO:
NEEDS BEYOND MEDICINE
P.O. 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.

Office Use Only

DATE RECEIVED __________ APPROVED _________ APPLICANT CONTACTED______________
DENIAL REASON ____