Needs Beyond Medicine®

Relief Program

NON-MEDICAL FINANCIAL ASSISTANCE

Program Overview

The primary focus of the Relief Program is to provide $500 grants to you as an adult cancer patient in Utah. These grants are designed to supplement your non-medical living expenses, such as housing, utilities, groceries, transportation, etc. It is our desire to assist in alleviating the stress of decreased income, as well as improve your quality of life and positively impact your medical outcomes as one of our grant recipients.

Our Mission

Needs Beyond Medicine has a mission to decrease the burden of cancer on those undergoing treatment by providing financial support for non-medical expenses.
Needs Beyond Medicine focuses on providing educational outreach regarding the importance of early cancer detection and prevention.

What to Expect

Applications are reviewed during the first week of each month. Application decisions 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, and when your application was received, it may be reviewed the following month. Please ensure your application is fully completed and legible, otherwise we will be unable to review your request. All applicants will be notified about the decision whether we can award the grant.

We understand you may be going through the lengthy process of completing forms and other documents and we recognize how draining that can be. You might find our requests similar in nature yet, by design. In order to offer you the greatest opportunity for assistance, we have included questions that we have found to be very beneficial in our approval process for you.

Generous Supporters of the Relief Program 2022:

SORENSON LEGACY FOUNDATION

Albertsons SAFEWAY

AMERICAN EXPRESS®

Personal Information

- Full Name: _____
- Address: _____
- City, State, Zip: _____
- Date of Birth: _____/_____/_____
- Gender: _____
- Phone Number: _____
- Email: _____
- Marital Status:
  __ Single (never married) __ Widowed __ Divorced
  __ Married __ Separated
- Household size (including yourself, spouse, and all dependents): _____
- Race:
  __ American Indian or Alaska Native
  __ Asian
  __ Black
  __ Caucasian (White)
  __ Hispanic/Latina/o/Spanish Origin
  __ Native Hawaiian or Pacific Islander
  __ Other (specify) _____
- Employment status:
  __ Full Time
  __ Part Time
  __ Self-employed
  __ Unemployed
  __ Unable to work
  __ Homemaker
  __ Student
  __ Retired
- ***If applicable,*** name of your employer: _____
- 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
- Do you have medical insurance? YES / NO
  i) If yes, what is the name of your medical insurance provider? _____
- 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

Assistance Request

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.

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

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

- Purpose of financial assistance requesting from Needs Beyond Medicine? (Select all that apply)

$ Amount- Please include requested dollar amount next to each item

_____ Rent/ Mortgage

_____ Transportation

_____ Groceries

_____ Utilities

_____ Recovery Items

_____ Other (please explain): _____

- 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

- Type of cancer you have been diagnosed with: _____
- Stage of cancer: _____
- Date diagnosed: _____/_____/_____ (**Most CURRENT diagnosis)**
- Is this a relapse of cancer? YES / NO
  a. If Yes, Original Diagnosis Type & Date: _____
- Name of your Doctor: _____

- Are you currently in active treatment (i.e. currently in chemotherapies/radiation treatments/etc.)

  (Surgeries/prescription pills are not considered treatment) YES / NO

  a. If NO, when will you start treatment: _____
- What type of treatment are you receiving (be specific)? _____
- Date current treatment began: _____/_____/_____
- Length of treatment (estimate and end date if possible): _____
- Medical facility where you receive treatment: _____

Referral

- How did you hear about Needs Beyond Medicine? _____
- Did a person or medical office refer you to us? Please name: _____
- Their Phone number: _____
- Their Address: _____
- 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 CANNOT BE ACCEPTED WITHOUT THE APPLICANT'S SIGNATURE.

PLEASE MAIL COMPLETED APPLICATIONS 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_____