



### What is the Financial Assistance Program for Non-Medical Necessities?

We understand the financial burden that comes with a cancer diagnosis and treatment. It inevitably puts stress on the entire family financial situation. The R-Giving Tree Foundation was founded to bring hope and dignity to those families facing or undergoing cancer treatments to help relieve some of the added financial pressures.

The R-Giving Tree Foundation, Inc's Financial Assistance Program for Non-Medical Necessities is available for qualified cancer patient families, currently anticipating or in cancer treatment with imminent financial need to help them with *non-medical family expenses*, such as: Rent, Utilities, Home Assistance, Auto Expenses, Groceries, Etc.

The Grant is a one-time grant of up to \$1,000 per qualified family.

### Program Eligibility Criteria:

1. Applicant must submit **a confirmed diagnosis of cancer patient anticipating or currently undergoing treatment confirmed and signed by their treating physician. (Medical Information Form)**
2. Applicant must submit **a completed and signed application** to The R-Giving Tree Foundation, Inc **(including story, photo and video release form)**.
3. Applicant must have a **household income at or below 500% of the Federal Poverty Level as adjusted for your state.**
4. Applicant must submit an **acceptable proof of income with application (a. or b. below):**  
Documentation for each working member of your household (e.g. spouse, parent working dependent, etc.) is required.
  - a. A copy of last year's federal tax return 1040 or 1040EZ (first 2 pages only) *or if you do not file tax returns*
  - b. A copy of a current SSI or SSDI award benefit letter(s) or last year's W-2s and/or 1099s.

### Instructions where to send completed Application, Medical Information Form and Proof of Income documentation to:

Fax: **714-492-7777** or Call **949-215-1327** for Assistance  
Email: **[info@rgivingtree.org](mailto:info@rgivingtree.org)**  
U.S. Mail: **The R-Giving Tree Foundation, Inc.**  
**c/o Grant Application Manager**  
**22600 Lambert Street, Suite 705-A**

**Lake Forest, CA 92630**

2018 Health & Human Services Poverty Guidelines & Dollar Figures may be found at:

<https://aspe.hhs.gov/poverty-guidelines>

The Federal Poverty Guidelines adapted are used as a reference tool only, it does not guarantee acceptance into the program. Currently applications are only being accepted for California and Nevada.

Information provided to R-Giving Tree Foundation is for our use only and will not be shared or sold.

**Assistance under this program is based on available funding and may be adjusted or discontinued at any time, without notice.**

For internal use only:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grant # \_\_\_\_\_



## Patient Information

The application must be completed in its entirety and must be signed by the Patient or Legal Guardian in the areas specified on the form below.

**Patient Name (First / Last):** \_\_\_\_\_

**Gender:**  Male  Female **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Date of Diagnosis:** \_\_\_\_/\_\_\_\_/\_\_\_\_

*If patient is less than 18 years of age, please also provide name of Parent or Legal Guardian below:*

**Parent or Legal Guardian name (First / Last):** \_\_\_\_\_

**Residential Address:** \_\_\_\_\_ **Apt. #** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_ **Zip:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Alt Phone:** (\_\_\_\_) \_\_\_\_\_ **Type:** \_\_\_\_\_ **Cell:** (\_\_\_\_) \_\_\_\_\_

**How did you hear about the R-Giving Tree Financial Assistance Program?**

Doctor  Nurse  Social Worker  Friend/Family  or Other (please specify): \_\_\_\_\_

**Which of the following best describes your race?**  Choose NOT to reply  White or Caucasian

Hispanic or Latino  Black or African-American  Asian  Native Hawaiian or another Pacific Islander

American Indian or Alaska Native  or Other \_\_\_\_\_

**US military Family:**  Yes or  No **May we contact you about your cancer story?**  Yes or  No

## Non-Medical needs for which you are applying.

*To be completed by the patient (if an independent adult), patient's responsible adult or legal guardian.*

*Please indicate those family bills (by amount) for which you wish of assistance. Do not submit bills, if needed we will request them.*

**Rent/Mortgage:** Payment \$ \_\_\_\_\_ Association. Dues \$ \_\_\_\_\_ **Groceries:** \$ \_\_\_\_\_

**Utilities:** Phone \$ \_\_\_\_\_ Gas \$ \_\_\_\_\_ Water \$ \_\_\_\_\_ Elec \$ \_\_\_\_\_ Trash \$ \_\_\_\_\_ Life Ins \$ \_\_\_\_\_

**Auto:** Car Payment \$ \_\_\_\_\_ License/Reg fees \$ \_\_\_\_\_ Auto Ins. Prem \$ \_\_\_\_\_

Auto Repair \$ \_\_\_\_\_ Repair Type: \_\_\_\_\_

**Home:** Home Cleaning \$ \_\_\_\_\_ \$ Home Repair \$ \_\_\_\_\_ \$ Education Fees \$ \_\_\_\_\_

**Other** \$ \_\_\_\_\_ please explain \_\_\_\_\_

*Any additional information that may help us understand your need:*

**YES I would like you to send an anonymous thank you message to the donor that made this grant possible.**

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## Household Financial Information

Please include proof of income as indicated on page 1 of this application. Proof of income documentation should be included for each member of your household (e.g. spouse, parent working child, etc.)

Number of people in the patient's household: \_\_\_\_\_ Is your family receiving any addition aid: [ ] Yes [ ] No

If Yes, please explain: \_\_\_\_\_

Household Employment: Patient? [ ] Yes [ ] No Guardian 1? [ ] Yes [ ] No [ ] N/A Guardian 2? [ ] Yes [ ] No [ ] N/A

Has this family received an R-Giving Tree Foundation grant before: [ ] Yes [ ] No What Year? \_\_\_\_\_

(a) This year's est. Annual Gross Income: \$ \_\_\_\_\_/Yr. (b) This year's est. Annual Expenses: \$ \_\_\_\_\_/Yr.

(a-b) This Year's Annual Net Income: \$ \_\_\_\_\_/Yr. This year's est. of Medical Expenses: \$ \_\_\_\_\_/Yr.

Name of person completing this form: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_\_) \_\_\_\_\_

## Patient Signature & Attestation

To be signed by the Patient (if an adult) or Patient's Legal Guardian.

By signing this form, I attest that the information provided is, to the best of my knowledge, true and accurate and if asked, I agree that I can, and will provide documentation supporting this household's annual income to be equal or less than indicated.

I further attest that if approved the funds will be used to pay family related Non-Medical expenses.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient/Guardian (Print Name, First Last): \_\_\_\_\_

Please send this signed and completed form to the R-Giving Tree Foundation, Inc. at:

- FAX: **714-492-7777** or Call **949-215-1327** for Assistance
- Email: [info@rgivingtree.org](mailto:info@rgivingtree.org)
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## Medical Information

To be completed by the patient's Treating Cancer Physician or Medical Designee.

Please note that stamps or initials will not be accepted. **Treating Physician Signature and License # are required.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Date of Diagnosis: \_\_\_/\_\_\_/\_\_\_

Diagnosis/Subtype/Stage: \_\_\_\_\_

Is patient in/or anticipating active cancer treatment and/or ongoing follow-up? [ ] Yes or [ ] No

If Yes, THIS treatment is: [ ] New [ ] Reoccurring [ ] Anticipated

Type of treatment: [ ] chemo infusion [ ] transplant [ ] oral targeted [ ] immune therapy [ ] CAR-T [ ] other

Treating Physician: \_\_\_\_\_

Medical License #: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Phone/Ext: (\_\_\_\_\_) \_\_\_\_\_ FAX #: (\_\_\_\_\_) \_\_\_\_\_

Hospital/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Treating Physician Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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## ***Patient's Story***

**Please describe the patient's and family's story below (include as much information as possible- location, family description, etc.):**

For internal use only:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grant # \_\_\_\_\_



## **PHOTO AND VIDEO RELEASE FORM**

I hereby grant The R Giving Tree Foundation permission to use my photograph, video, or other digital media (“photo”) in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of The R Giving Tree Foundation finished product wherein my photo appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge The R Giving Tree Foundation from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ | Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

For internal use only:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Grant # \_\_\_\_\_