FINANCIAL ASSISTANCE PROGRAM FOR NON-MEDICAL NECESSITIES - APPLICATION FORM

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

We understand the financial toxicity that comes with a cancer diagnosis and treatment. It inevitably puts stress on the entire family financial situation. R-Giving Tree 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 S1,000 per qualified family.

Program Eligibility Criteria:

1. Must submit **a confirmed diagnosis of cancer patient anticipating or currently undergoing treatment confirmed and signed by their treating physician. (Medical Information Form)**
2. Must **live in California or Nevada**.
3. Must submit **a completed and signed application** to R-Giving Tree Foundation, Inc.
4. Must have a **household income at or below 500% of the Federal Poverty Level as adjusted for your state.**
5. Must submit **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.

Where to send completed Application, Medical Information Form and Proof of Income documentation to:

Fax to: **714-492-7777** or **Call 714-215-1327 for Assistance**
Email to: **info@rgivingtreefoundation.org**
Mail to: **R-Giving Tree Foundation, Inc.**
Attn: 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 # _____

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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 to: **714-492-7777** or Call **714-215-1327** for Assistance
- Email to: **info@rgivingtreefoundation.org**
- Mail to: **R-Giving Tree Foundation, Inc.**
  Attn: Grant Application Manager
  22600 Lambert Street, Suite 705-A
  Lake Forest, CA 92630

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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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