Angels Among Us 501(c)3
3516 N 163rd Plaza Ste 3
Omaha NE 68116
402-934-0999
shari@myangelsmaongus.org

Financial Assistance Application

HERE IS WHAT WE DO...

Our mission is: *"To financially assist families with a child battling cancer living in or being treated in Nebraska."* When a child is diagnosed with cancer, not only is the news emotionally devastating for you as a parent, it can become financially difficult as well. Our goal is to help reduce the amount of stress in your lives, so that you can focus more of your attention on your child, and channel your energy and efforts towards recovery, rather than stressing and worrying about your finances.

HERE IS HOW IT WORKS...

We ask you to fill out this application form **in its entirety**, and return it via postal mail, email, to our office or fax to your hospital social worker. Please be aware that we have a limitation as to how many families we can assist at one time, so it may be necessary to place you on a wait list for a couple of months. Once approved, you will receive a phone call directly from our office to let you know that we are ready to provide you with financial assistance. A program guidelines letter will be mailed to you. You will receive a $500.00 monthly allocation, up to $9,000.00 total (18 months), while your child is going through treatments. We pay your creditor(s) directly on your behalf, to ensure proper use of funds.

THIS WE NEED FROM YOU...

You must submit a copy of your bill(s), as we pay the creditors directly on your behalf. We will need the account number, address, and phone for the creditor. This is not a loan and you will not need to repay it. It is simply the mission of our organization to help families in need, like yours.

_____

Child being treated: Full Name (Please Print)

Child's age: _____ Date of Birth: _____ Male: ☐ Female: ☐

_____

Parent/Guardian Full Name (please print)

_____

Parent/Guardian Full Name (please print)

For Office Use Only:

Date Received: _____ What we are paying: _____

Start Date: _____ AG: _____ RG: _____

Marital Status: Single: ☐ Married: ☐ Widowed: ☐ Divorced: ☐ Separated: ☐

Other adults (19+) contributing to house hold:_____

Name(s) (Please Print)

List all children under the age of 19 living in household (if additional space is needed please attach or write on the back of form):

Name: _____ DOB (MM/DD/YYY): _____ Male: ☐ Female: ☐
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Address: _____

City: _____ State: _____ Zip Code: _____

County: _____

Primary Phone Number: _____ Indicate: Home ☐ Cell ☐ Work ☐

Other: _____ Indicate: Home ☐ Cell ☐ Work ☐

Best Time to contact: Morning ☐ Afternoon ☐ Evening ☐

_____

Email Address (please print clearly)

_____

CaringBridge/Care Pages Log-In Information/Facebook page

Preferred Language in home: English ☐ Spanish ☐ Other: _____

To which racial or ethnic group do you most identify?
☐American Indian or Alaskan Native ☐Asian Or Pacific Islander ☐Black, not of Hispanic origin ☐Hispanic
☐White, not of Hispanic origin, ☐Other_____

Child's Diagnosis _____Date_____ Overseeing Doctor_____

How long has he/she been treated? _____ Port? ☐ How long in/or when removed? _____

Anticipated length of treatment: _____

What hospital(s) is child currently being treated at? _____

Who were you referred ☐ A hospital social worker? If so, who? _____
☐ Other—Name: _____

Proof of Income

Other Income Source Documentation (check all that apply)

☐ VA Assistance ☐ Alimony ☐ Child Support ☐ Disability ☐ Life Insurance
☐ Railroad Retirement ☐ Unemployment ☐ Social Security ☐ Public Assistance ☐ Other
☐ Military Retirement/Pension

Have you recently applied for or been approved for Medicaid? (Check box if yes) ☐

Assets		**Liabilities**	
Cash on hand (include checking)	$_____	Mortgage	$_____
Savings	$_____	Second Mortgage	$_____
Stocks/Bonds/Retirement Funds	$_____	Bank Loans	$_____
Vehicles Estimated Total Value		Total Credit Card Debt	$_____
Model _____Year _____	$_____	Student Loans	$_____
Model _____Year _____	$_____	Other Liabilities	$_____
Model _____Year _____	$_____		
Home: Estimated Market Value	$_____		
Other Assets	$_____		
Other Assets	$_____		
Total Assets	$_____	**Total Liabilities**	$_____

Net Worth (Total Assets – Total Liabilities) $_____

Monthly Expenses

Mortgage/Rent	$_____
Utilities	$_____
Telephone	$_____
Medical Bills	$_____
Insurance: Health	$_____
Insurance: Auto	$_____
Insurance: Home/ Renters	$_____
Prescription Drugs	$_____
Medical Equipment	$_____
Groceries	$_____
Childcare/ Eldercare	$_____
Child Support	$_____
Other	$_____
Total Monthly Expenses	**$_____**

In addition to completing this form, please attach copies of the following items:

- ☐ Current pay stub (if a two-income household, please provide for both working adults)
- ☐ Copy of entire bill(s) or statement(s) you would like paid if approved (up to $500 a month)
  - The bill or statement needs to include account number, address, and phone number of payee

Explain any circumstances that would further clarify the information reported above. Attach additional pages if needed.

_____

_____

CONFIDENTIALITY CLAUSE

☐ Y ☐ N

_____ Initial

Angels Among Us considers this application, and its attached information, confidential. Angels Among Us shall not use the Confidential Information other than for the purposes of its business with the applicant, and shall disclose it only to its officers, board members, or government agencies with a specific need to know. Angels Among Us will not disclose, publish, or otherwise reveal any of the Confidential Information received from applicant to any other party whatsoever except with the specific prior written authorization of Applicant. By signing below, you give Angels Among Us, Inc authorization to speak with the social work department and/ or Doctors to verify your situation.

PUBLICITY AUTHORIZATION

☐ Y ☐ N

_____ Initial

(Publicity O.K.) I authorize Angels Among Us to publicize information about my family (including a Child's medical condition, whether embodied in photographs, videotapes, recordings, and any other format (collectively, "Information"), for the purposes of promotion, publication, commercial advertising, or any other purpose whatsoever, now or at any time in the future. Participants understand and agree that Angels Among Us may use any such Information: (1) in all manner and media whatsoever, whether now known or hereafter invented, including electronic and print media and the Internet; (2) with or without Participants' names; (3) without the payment of royalties or other compensation to anyone; and (4) without the need to notify them or to seek further approval before doing so.

FEATURED FAMILY

☐ Y ☐ N

_____ Initial

I hereby consent that my family would be willing to participate as a Featured Family at a future Angels Among Us event. This includes, but is not limited to, participating in future events, and telling my family story.

Parent/Guardian Signature_____ Date _____

Confidentiality Agreement: Checking the boxes and signing your name on this consent form authorizes Angels Among Us, to use the information provided. All forms sent to Angels Among Us will be held in complete confidence during internal processing. No information will be given to a third party for any reason.

Certification

I certify that the information provided is accurate and complete to the best of my knowledge.

_____

Parent/Guardian Signature Date Parent/Guardian Signature Date