



Angels Among Us, 501(c)(3)
3516 N 163rd Plaza Ste 3
Omaha, NE 68116
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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/YYYY): _____	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Name: _____	DOB (MM/DD/YYYY): _____	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Name: _____	DOB (MM/DD/YYYY): _____	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>
Name: _____	DOB (MM/DD/YYYY): _____	Male: <input type="checkbox"/>	Female: <input type="checkbox"/>

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)

- | | | | | |
|------------------------------------------------------|---------------------------------------|------------------------------------------|--------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> VA Assistance | <input type="checkbox"/> Alimony | <input type="checkbox"/> Child Support | <input type="checkbox"/> Disability | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> Railroad Retirement | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Social Security | <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Military Retirement/Pension | | | | |

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

Assets

Cash on hand (include checking) \$ _____
 Savings \$ _____
 Stocks/Bonds/Retirement Funds \$ _____
 Vehicles Estimated Total Value
 Model _____ Year _____ \$ _____
 Model _____ Year _____ \$ _____
 Model _____ Year _____ \$ _____

Home: Estimated Market Value \$ _____
 Other Assets \$ _____
 Other Assets \$ _____

Total Assets \$ _____

Liabilities

Mortgage \$ _____
 Second Mortgage \$ _____
 Bank Loans \$ _____
 Total Credit Card Debt \$ _____
 Student Loans \$ _____
 Other Liabilities \$ _____

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.

Consent Form

CONFIDENTIALITY CLAUSE

Y N

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.

Initial

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

(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.

Initial

FEATURED FAMILY

Y N

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.

Initial

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

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