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 to your hospital social worker. Once approved, you will receive a phone call or email 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 based on your child's treatment plan.

THIS WE NEED FROM YOU…

You must submit a copy of the bill(s) you are requesting we assist with, 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.

______________________________ Child's Age: ____________ Date of Birth:______________________

Child being treated: Full Name (Please Print) Male: ☐ Female: ☐

______________________________________ ______________________________________

Parent/Guardian Full Name (please print) Parent/Guardian Full Name (please print)

Address: ______________________________ City: ________________ State: __________ Zip Code: ________

County: ____________________ **Email Address (please print clearly)** ______________________________

Primary Phone Number: ______________ Indicate: Home ☐ Cell ☐ Work ☐ Preferred Method of contact:

Other Phone Number: ________________ Indicate: Home ☐ Cell ☐ Work ☐ ☐ Phone ☐ Email

Preferred method to receive monthly statements: ☐ Regular mail ☐ Email______________________

Facebook page/CaringBridge/Account Information ______________________________________

For Office Use Only:	Date Received: _____________	What we are paying: _____________	
Start Date: _____________	AG: ____________	RG: ____________	LOA:___________

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

Does the child reside primarily with the applicant: Yes ☐ No ☐ if no, please explain on separate sheet.

Other adults (19+) contributing to house-hold income: ____

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: ☐ Female: ☐
Name: ______________________ DOB (MM/DD/YYYY): ________________ Male: ☐ Female: ☐
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Name: ______________________ DOB (MM/DD/YYYY): ________________ Male: ☐ Female: ☐

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

☐Bi-Racial ☐Other___________________________________

Child's Diagnosis ____ Date of Diagnosis__________

Overseeing Doctor______________________________________ Anticipated remaining treatment plan in months: __________________________

How long has he/she been treated? ______________ Does Child have a Port? ☐How long in/or when removed? ____________________

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

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

Proof of Income

A. Total Employment Income – Net Amount per month $____________________

B. Other Income Source Documentation-Type and Amount per month (complete all that apply)

☐Alimony $_________________ ☐Child Support $______________ ☐Disability $__________________ ☐Life Insurance $_____________

☐Public Assistance $___________ ☐Social Security $______________ ☐ Retirement/Pension(Military or other)__________________________

☐Unemployment $____________

☐VA Assistance $_____________ ☐ Any Go Fund Me/Online Fundraisers $___________________ ☐Other $____________________

C. Monthly Expenses

Mortgage/Rent	$_______________	Is Mortgage or Lease in your name? ☐Yes ☐No-Explain below
Utilities	$_______________	____
Telephone	$_______________	____
Medical Bills	$_______________	____
Insurance: Health	$_______________	____
Insurance: Auto	$_______________	____
Insurance: Home/ Renters	$_______________	____
Prescription Drugs	$_______________	____
Medical Equipment	$_______________	____
Groceries	$_______________	
Childcare/ Eldercare	$_______________	
Child Support Payments	$_______________	
Wage Garnishment	$_______________	

Total Monthly Expenses **$_______________**

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_________________	$______________		
Total Assets	**$______________**	**Total Liabilities**	**$______________**

Net Worth (Total Assets – Total Liabilities) $______________

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) [from A above]
- ☐ Please attach a copy of most recent statement/paystub for all income. [from B above]
- ☐ 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 on back any circumstances that would further clarify the information reported above. Attach additional pages if needed. Angels Among Us reserves the right to deny funding for incomplete or inaccurate applications and/or if funding is not available.

There may be other financial avenues for you to investigate outside of funding through Angels Among Us. We encourage you to contact a tax professional about those possible avenues. Feel Free to also visit the following websites for information:

www.necancernetwork.org
www.nebc3.com

QUESTIONS ABOUT THIS APPLICATION? PLEASE CONTACT:
Angels Among Us
3858 Jones Street, Suite A, Omaha, NE 68105
402-934-0999

CONSENT FORM

For Angels Among Us to evaluate and process the applicant's request for financial assistance, Angels Among Us is required to verify certain financial information of the applicant as set forth in this Consent Form. If, after verification, Angels Among Us determines that any information provided is not fully complete or accurate, Angels Among Us reserves the right to rescind or alter any offer of financial assistance. **Carefully read this Consent Form, complete each section by marking and initialing your response, and sign/date where indicated at the end.**

EMPLOYEMENT VERIFICATION

_____ Y _____N By completing this application for assistance you grant permission to Angels Among Us to verify specific information listed within the application. Items that Angels Among Us would verify include home ownership and employment verification. By initialing you grant permission for Angels Among Us to verify the information provided. If, after verification, we deem information to be not fully complete, we have the right to rescind or alter funding.

_______initial

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. 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 the Applicant. By initialing and signing below, you give Angels Among Us authorization to speak with the social work department and/or doctors to verify your situation.

________initial

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, nor 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 or 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

BAGS OF FUN

_____ Y _____N I give permission for my child to receive a Bag of Fun through Bags of Fund and have signed the consent form attached to this application.

_________ initial

Confidentiality Agreement: Checking the "Yes" 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 unless agreed upon above. I certify that the information provided is accurate and complete to the best of my knowledge.

Parent/Guardian Signature: ______________________________________ Date: ___/___/______ Contact Phone/Email: ______________________________

Bags of Fun Information Form

Bags of fun is a Colorado-based organization whose mission is to deliver a Bag of Fun to every sick child whose health and happiness is both compromised and threatened. All bags are age, gender, and diagnosis specific and all include a Kindle and rehabilitative toys. Angels Among Us has partnered with this organization to ensure all our cancer families get the opportunity to receive a bag during their treatment journey.

☐ By marking this box you are giving Angels Among Us permission to share the below information with Bags of Fun for the sole purpose of ensuring the development of a custom bag and for Bags of Fun to contact you about delivery of the gift bag as necessary.

Parent/Legal Guardian Signature: ____________________________ Date: _____________________

Information needed:

Patient Name:____________________________ Patient Age: __________ Patient Gender (circle one): M F Diagnosis:____________________________________

In Patient Out Patient (circle one) Any developmental delays or physical restrictions: ____

Primary Language of Family: ____________________Primary Language of Child:____________________

Sibling(s) Name(s) (include ages):

____

Favorites:

Child's Favorite Color:____________________ Child's Favorite Character: ______________________ Any others: ____

Circle any of the below categories that may interest your child:

Dinosaurs Trucks/Cars Magic/Spy Gear Princesses Dogs Cats Building things Puzzles/Games Drawing/Art/Clay Sewing

Jewelry Crafts Science/Lab Dolls LEGOS Tech Savvy/Robots