



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: Cohabiting: 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: <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"/>

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

Cash on hand (include checking) \$ _____

Liabilities

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)
 - o **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.**

EMPLOYMENT 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, 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 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's 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 of our cancer families get the opportunity to receive a bag during their treatment.

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.

(Publicity O.K.) I authorize Bags of Fun 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 Bags of Fun 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.

I would like to join Bags of Fun's email list. If mark yes, please list e-mail here: _____

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: _____

Please circle any of the below that 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