Financial Assistance Application

Full of Hope Foundation is a 503C foundation whose mission is to assist cancer patients in the state of Arizona with non-medical financial assistance while in active treatment. The foundation is supported through fundraising efforts and donations from corporations and individuals.

Here are a few things you should know:

1. Applications for the Full of Hope Foundation are due on the FIRST FRIDAY OF EVERY MONTH. Late applications will be treated as LATE and will be considered at the meeting on the following month.

2. Applications will be reviewed by the Full of Hope Foundation committee on the SECOND Wednesday OF EVERY MONTH.

3. You must be receiving a cancer-related treatment at a medical facility in Arizona to be eligible to apply for assistance.

4. Applicants can apply no more than three times a year with a maximum award of $1,000 per year.

5. Please ensure the entire application form is completed, including copies of the bills applicant is requesting to be paid, and a copy of most recent bank statement. Incomplete forms or applications without bills attached WILL NOT BE CONSIDERED UNTIL COMPLETE.

6. Each request will be reviewed individually and awarded entirely based on need, regardless of doctor or medical facility where treatment is received.

7. The amount of assistance granted will depend on the amount of funds available and the financial status of the applicant.

8. Completing an application does not guarantee you will receive funds.

9. The information you provide on your application is kept in the strictest confidence. Please allow us the same courtesy regarding the amount of funds provided to you.

10. Full of Hope will consider financial aid assistance for community support services on a case by case basis.

Full of Hope Foundation cannot provide financial assistance for any doctor bills, hospital bills, prescriptions or other medical expenses.

APPLICATION CHECKLIST:

Complete Application with Applicant Signature ☐
Supporting Bills for Amount Requested ☐
Recent Bank Statement to Support Request ☐

Physician Certification Completed with Signature ☐

Application for Financial Assistance

Instructions: If you have cancer and need financial assistance, please complete this application with supporting bills and bank statements. Please return it with the completed physician certification by mail at address listed below. Incomplete applications or applications without supporting bills will not be considered. For more information visit us online at fullofhopefoundation.org.

Full of Hope Foundation
1900 W. Chandler Blvd., Ste 15-153
Chandler, AZ 85224

LAST NAME:_______________ FIRST NAME:__________________ DOB:____________SSN:______________

ADDRESS:____

CITY: _____________________ State: AZ ZIP:_________________ Phone: ____________________________

ALTERNATE PHONE: ___________________________ E-MAIL: _______________________________________

Patient information (must be over the age of 18):

MALE _______ Employed and Working Full Time ______ Unemployed ________

FEMALE ______ Employed and Working Part Time ______ Disabled _________

Employed but on FMLA/Disability/Leave _______ Student _________

Diagnosis and condition of patient: ____

No. Living in Household ___________ Ages of children (under age 18) in household __________________

Total Amount Requesting $

Mortgage/Rent Relief $_______ Utility Bills $________ Car Payment $_____________

Medical Equipment $_______ OTHER $________

Note: Applicant MUST include a copy of the bill they are requesting to be paid. We pay the vendors directly and do not provide any cash to the applicant. We do not provide financial assistance for doctor bills, prescription medications, co-pays, deductibles, or treatment expenses.

	APPLICANT	SPOUSE	OTHER PERSONS
Employer			
Type of Work			

ASSETS (List Current Value)			
	APPLICANT	SPOUSE	OTHER PERSONS
Checking Accounts	$	$	$
Savings Accounts	$	$	$
Other Investments	$	$	$
Liquid Accounts	$	$	$

*You must provide a recent copy of these bank statements with your completed application.

SOURCES OF INCOME (List monthly amounts)			
	APPLICANT	SPOUSE	OTHER PERSONS
Net Wages (after taxes)	$	$	$
Unemployment	$	$	$
Sick Pay	$	$	$
Social Security	$	$	$
Short/Long term disability	$	$	$
Retirement Benefits	$	$	$
Rental/Investment Income	$	$	$
Alimony	$	$	$
Child Support	$	$	$
Trust Fund	$	$	$
Welfare	$	$	$
Military Benefits	$	$	$
Charitable Support	$	$	$
Other (list)	$	$	$
Total	$	$	$
TOTAL MONTHLY HOUSEHOLD INCOME $			

*Note: You may be asked to provide more documentation including recent pay stubs to support this application.

EXPENSES (List monthly amounts)			
	APPLICANT	SPOUSE	OTHER PERSONS
Rent or Mortgage	$	$	$
Gas	$	$	$
Electric	$	$	$
Sewer/Water	$	$	$
Telephone/Cell	$	$	$
Car Payments	$	$	$
Car Insurance	$	$	$
Gasoline	$	$	$
Food	$	$	$
Health Insurance	$	$	$
Life Insurance	$	$	$
Medications	$	$	$
Child Care	$	$	$
Credit Cards	$	$	$
Other Payments	$	$	$
Total	$	$	$
TOTAL MONTHLY HOUSEHOLD EXPENSES $			

Do you have health insurance (including Medicare/Medicaid) □**YES** □**NO**

Do you have secondary insurance? □**YES** □**NO**

Have you received any assistance from a local or national charity? □**YES** □**NO**

Do you have a Go Fund Me Page/fundraising page for your family? □**YES** □**NO** If yes, list the donation page(s) here: __________________________.

PATIENT STATEMENT AND SIGNATURE

By signing below, I authorize Full of Hope Foundation to obtain and discuss information related to this application with my physician and other care providers. I certify that the above statements are true. Payment is dependent upon availability of funds. Funds are not always available each month. All information related to this application will be kept strictly confidential and will not be share with outside persons or agencies. Grants will be awarded based on need and without regard to race, national origin, gender, sexual orientation, physician, or medical care facility and may be suspended at any time due to unavailability of funds. Verification of information may be required.

Signature	Date Signed

ONCOLOGY OFFICE CERTIFICATION

This form is to be completed by your oncologist.

I certify that ____ (patient name) is being ACTIVELY

treated for ____ (diagnosis).

Treatment type: (please check all that apply)

__________ IV Chemotherapy _____________ Surgery

__________ Oral Chemotherapy _____________ Radiation Therapy

Other (please describe briefly) _____________________________________

The patient is expected to be under ACTIVE treatment for ________________________________ (time frame).

Treating Physician Name (printed)	
Oncologist's Signature (or Authorized Representative)	Date Signed

Must be dated within 60 days of application. Applications without a time frame will may not be considered. If you need assistance with this application, please contact us on our website at www.fullofhopefoundation.org.