



Financial Assistance Application

Full of Hope Foundation is a group of volunteers who raise funds to help reduce the non-medical expenses of patients actively receiving cancer treatment. It is supported through fundraising efforts and other donations from corporations and individuals.

Here are a few things you should know:

1. Applications for the Full of Hope Foundation are due 1st of the 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 first Tuesday of every month with the exception of major holidays.
3. You must be received at an Arizona medical facility 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 a 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. Assistance will be paid directly to the account center and not to the applicant. Please include account numbers and addresses where check may be sent.
10. The information you provide on your application is kept in the strictest confidence.
11. Full of Hope will consider financial 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, insurance premiums, prescriptions or other medical expenses.

APPLICATION CHECKLIST:

- | | |
|--|--------------------------|
| Complete Application with Applicant Signature | <input type="checkbox"/> |
| Supporting Bills for Amount Requested | <input type="checkbox"/> |
| Recent Bank Statement to Support Request | <input type="checkbox"/> |
| Physician Certification Completed with Signature | <input type="checkbox"/> |



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, fax, or email. Incomplete applications or applications with supporting bills will not be considered. For more information visit us online at fullofhopefoundation.org. You may e-mail your completed application to Kelly@fullofhopefoundation.org or mail to:

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: _____ EMAIL: _____

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 \$ _____

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. Assistance will be paid directly to the account center and not to the applicant. Please include account numbers and addresses where check may be sent.

Employment Information			
	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/AHCCCS)

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: _____.

Have you had any previous delinquencies regarding the accounts you are asking for assistance with?

YES NO

If so when and why?

_____.

Please explain what your plan is to pay these accounts moving forward?

_____.

Have you had any previous evictions?

YES NO If so when and why?

_____.

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.fullofhopecfoundation.org.