Full of Hope
Foundation

Financial Assistance Application

The Full of Hope Foundation is a group of volunteers who raise funds to assist cancer patients with their non-medical expenses.

Application Requirements:

- Applications are due the 1st of each month. Applications received after the 1st will be reviewed the following month.
- You must be in **active** treatment (i.e. Chemotherapy, Radiation Therapy, Immunotherapy, or have had cancer-related surgery within the last 30 days) at an Arizona facility to be eligible for assistance.
- Applicants can apply for maximum award of $1,000 per calendar year.

Important information:

- The Full of Hope Foundation cannot provide financial assistance for any doctor bills, hospital bills, insurance premiums, prescriptions, or credit cards.
- Email inquiries regarding application status will not be returned, as applicants will be notified of approval or denial by U.S. Postal mail.
- Completing an application does not guarantee funds. Funds are dispersed based on need and funds available regardless of treating physician or where treatment is received.
- The information provided on your application will be kept in the strictest confidence and used only for the purpose of determining eligibility.
- If assistance is approved, the funds will be paid directly to the account center and not the applicant. Please include all numbers and addresses where the payment will be made to.

Please ensure the entire application form is completed, as incomplete applications will not be considered. Please see checklist below.

APPLICATION CHECKLIST:

- Complete application with applicant signature
- Supporting bills in the amount requested in the applicant's name
- Recent bank statement to support request in applicant's name
- Physician Certification completed with signature

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Application for Financial Assistance

Instructions: Please complete the application and provide the supporting bills and (recent) bank statements. Please return it with the completed physician certification by mail or email. You may e-mail your completed application packet to: ***info@fullofhopefoundation.org*** or mail to:

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

FIRST NAME:_____ LAST NAME: _____DOB: _____SSN:_____

ADDRESS: _____

CITY: _____ State: _____ ZIP: _____Phone: _____

ALTERNATE PHONE: _____ EMAIL: _____

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

Employed and Working: Full Time ____ Part Time ____ Disabled ____Unemployed ____

Employed but on FMLA/Disability/Leave ____ Student ____

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

Total Amount Requesting: $ (Maximum amount $1000)

Mortgage/Rent $:_____Gas $:_____ Electric $:_____Water/Sewage $:_____ HOA $:_____

Car Payment $:_____Car Insurance $:_____ Phone $:_____ Internet $:_____

- Bills **MUST** be attached and in the applicant's name
- No credit card payments or medical bills will be paid

Assets (List Current Value)			
	Applicant	**Spouse / Partner**	**Other Persons**
Checking Accounts	$	$	$
Savings Accounts	$	$	$

Sources of Income (List Monthly Amounts)			
	Applicant	**Spouse / Partner**	**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	**$**	**$**	**$**

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	$	$	$
Medications	$	$	$
Child Care	$	$	$
Credit Cards	$	$	$
Other Payments	$	$	$
Total	$	$	$
Total Monthly Household Expenses $			

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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

_____ Immunotherapy

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.

1. Do you have health insurance? □**YES** □ **NO?** If yes, what insurance? _____.

2. Do you have secondary insurance? □**YES** □**NO** If so, what insurance? _____.

3. Have you received any assistance from a charity? □**YES** □**NO**

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

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

□**YES** □**NO** If so, when and why?

_____.

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

_____

_____.

7. Have you had any previous evictions? □**YES** □**NO**

If so, when and why? _____.

Patient Statement and Signature

By signing below, I authorize The 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