Light of Hope CANCER FOUNDATION

Mission

To empower local cancer patients and families to focus on treatment and healing by providing immediate and practical financial support while advocating and fundraising for research, education, and cancer prevention.

Date of application: _____
Received by: _____

Light of Hope Statement:

To provide practical and immediate financial support to local cancer patients and their families so they can focus on healing.

Please read the following paragraph before completing the application:

1. To be eligible, you must be living in Rice County or receiving treatment in Rice County; and in active treatment for cancer, including chemotherapy/immunotherapy, radiation, and/or surgery with a recovery time of more than four weeks.

2. Financial Program Grants are available to oncology patients to provide additional financial assistance due to extreme hardship.

3. Financial Program applications are considered and processed pursuant to Light of Hope guidelines, which are available online or a hard copy can be provided upon request for details.

4. Please have the first and last name and contact information of your Social Worker, Nurse Navigator, or Medical Provider.

5. Financial Program Grants are generally paid directly to the company owed. Please have the name, your account number and the address of the company owed ready.

6. Have not received Light of Hope Cancer Foundation Funding in the prior 12 months of application date.

7. Maximum funding for 2024 is $1,000 per individual.

Patient Information

Date: _____

First Name:_____Last Name: _____

Primary Address: _____

City:_____State:_____Zip Code: _____

County: _____ Phone Number *(with area code)*: _____

Email Address: _____Birthdate:_____

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Have you received assistance from Light of Hope in the past 12 months? Please check your answer.

YES ☐ NO ☐

If yes, approximately what date did you apply? _____

Gender *(please check one)*: Male ☐ Female ☐ Prefer not to disclose ☐ Other ☐

Family Information

What is your annual household income?_____

How many family members reside in your household? _____

Please indicate any/all treatment-related hardships *(check all that apply)*: (At least one box required)

- ☐ One or more inpatient hospitalizations in the past 90 days
- ☐ Current treatment for cancer
- ☐ Immediate family member(s), who are uninsured **and** unemployed, have (or had) a serious chronic illness in the past 12 months
- ☐ None of the above apply

Employment and Life *(check all that apply)*: (At least one box required to be checked)

- ☐ Patient earns primary income
- ☐ Patient is on unpaid leave or unemployed
- ☐ Patient is currently receiving short-term disability
- ☐ Other adults in home are on unpaid leave or unemployed
- ☐ Patient does not have reliable transportation
- ☐ Patient does not have stable housing
- ☐ Patient does not have health insurance
- ☐ Retired
- ☐ None of the above apply

In order to help us understand your needs, please provide additional detail related to any boxes you checked in the Employment and Life section.

_____

_____

_____

_____

Please provide any additional information such as date of onset, treatment status, family dynamics, and economic situation (family or personal) that would be helpful to evaluate the application:

_____

_____

_____

_____

_____

Hospital/Clinic Information

Name of Primary Cancer Center Care Facility: _____

City:_____State:_____Zip Code: _____

Name of Social Worker/Healthcare Provider *(First & Last)*: _____

Phone Number and/or email of Social Worker/Healthcare Provider: _____

Grant and Payment Information:

Type of expense or bill needing payment *(Check all that apply)*: (At least one box required to be checked)

- ☐ Mortgage payment
- ☐ Rent payment
- ☐ Utilities
- ☐ Transportation
- ☐ Gas Card
- ☐ Childcare
- ☐ Grocery Gift Card
- ☐ Other

Check Payable To (Name of Creditor): _____

Account Number with Creditor: _____

Creditor Address: _____

City:_____State:_____Zip Code: _____

Creditor Phone Number: _____

Requested amount:_____Due Date: _____

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Additional comments on the amount/type of request:

_____

_____

_____

Authorization (paragraphs 1 and 3 are required)

☐ I authorize the verifier (healthcare provider, social worker, etc.) provided on this form to release information (including diagnosis, treatment status and other pertinent information related to grant request) to Light of Hope Foundation as necessary to determine eligibility and processing of this grant request.

☐ I would like to share my story; my cancer journey and how Light of Hope Foundation has helped me. Please contact me.

☐ I understand that my personal information will not be published or shared with the public or a third party, except as provided herein, without my consent. Personal information is defined as home address, phone number, email address, medical information, and creditor information.

☐ I would like to keep up to date on Light of Hope Foundation's work in the community. Please include me on your newsletter and mailing distribution.

☐ I have not received assistance from the Light go Hope Cancer Foundation in the prior 12 months of the date of my application.

Applicant Signature: _____

Person Completing the Form: _____

Relationship to Person Completing the Form: _____

Date: _____

***A COPY OF BILL MUST BE INCLUDED WITH APPLICATION (on conditions boxes checked are not transportation or grocery.**

LOH Website and Facebook information:
Facebook page: Light of Hope Cancer Foundation
Website: www.lightofhopemn.org
Email Address: info@lightofhopemn.org
Mailing Address: PO Box 934 - Faribault, MN 55021

For Internal Use Only:

Date received:_____ Date Approved/Denied:_____ Amount Granted:_____ Comments:_____