Emergency Assistance Grant Application

Please read the following paragraph before completing the Emergency Assistance Grant Application:

1. You must currently be in treatment for breast cancer in the state of Minnesota.
2. This application should take you between 5-10 minutes to complete.
3. Please have the first and last name, email address and phone number of your Social Worker/Nurse Navigator. They will need to verify treatment before grant application can be approved.
4. Grants are paid directly to the company owed. Please have the name, account number and address of the company owed ready.
5. You will need to provide a copy of the bill(s) you wish to be paid.

Patient Information

First Name: ____________________________ Last Name: __________________________________

Primary Address: ____

City: _________________________________ State: _________ Zip Code: ___________________

Phone Number (with area code): ____

Email Address: ____

How did you hear about Hope Chest for Breast Cancer? _____________________________________

Have you received a grant from Hope Chest in the last 12 months? Please circle your answer.
YES NO

Birthdate: ______________________________ (MM/DD/YYYY) Age: ________________________

Gender (please circle your answer): MALE FEMALE

Ethnicity (please circle your answer):

American Indian   Asian or Pacific Islander   Black or African American   Caucasian

Hispanic or Latino   Multiracial   Other

Diagnosis (please circle your answer):

DCIS Ductal Carcinoma In Situ   IDC Invasive Ductal Carcinoma   ILC Invasive Lobular Carcinoma

LCIS Lobular Carcinoma In Situ   Inflammatory Breast Cancer   Recurrent or Metastatic

Unsure of diagnosis

(Application continues on next page)

Diagnosis Status (please circle your answer):

New diagnosis (<6 months) Existing diagnosis (7mo – 2yr) Relapse diagnosis (2+ yrs)

New diagnosis in advanced stage and/or aggressive disease Unsure of diagnosis

Family Information

How many adults live in your household? ________________ Children? ______________________

Marital Status: _______________________ Annual Household Income: ______________________

Treatment Related Hardships (check all that apply):

- ☐ Travel 2+ hours for hospital/clinic visits
- ☐ Seeking temporary housing to be closer to hospital
- ☐ Frequent clinic visits (2+ times/week)
- ☐ Hospitalized 15 of last 90 days
- ☐ Hospitalized 30 of last 90 days
- ☐ Family has lost additional member(s) with serious chronic illness
- ☐ Prescribed therapy out of state
- ☐ End of life / hospice / bereavement

Employment and Life (check all that apply):

- ☐ Patient is on unpaid leave or unemployed
- ☐ Other adults in home are on unpaid leave or unemployed
- ☐ Primary household earner is self-employed
- ☐ No reliable transportation
- ☐ No stable housing

If you checked any of the boxes above (Employment and Life), please provide more details below:

____
____
____
____
____

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:

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(Application continues on next page)

Hospital/Clinic Information

Primary Hospital: ____

City: _________________________________ State: _____________

Name of Oncology/Radiation Care Facility: ____

City: _________________________________ State: _____________

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

Phone Number of Social Worker/Healthcare Provider: _______________________________________

Email Address of Social Worker/Healthcare Provider: _______________________________________

Grant and Payment Information:

Would you like meal assistance? Please circle your answer. YES NO

Type of Payment (Please check your answer):

- ☐ Mortgage payment
- ☐ Rent payment
- ☐ Utilities
- ☐ Transportation
  - ☐ Gas Card
  - ☐ Bus/Cab Fare
- ☐ Childcare
- ☐ Grocery cards
- ☐ Meals only
- ☐ Other

Check Payable To (Name of Creditor): ____

Account Number with Creditor: ____

Creditor Address: ____

City: _____________________________________ State: _________ Zip Code: ______________________

Creditor Phone Number: ____

Requested amount: _________________ Due Date: _____________________ (MM/DD/YYYY)

MUST INCLDUE A COPY OF BILL WITH APPLICATION

Additional details for meal delivery: ____

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Additional comments on the amount/type of request: ____

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(Application continues on next page)

Authorization

- ☐ 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 Hope Chest for Breast Cancer Foundation as necessary to determine eligibility and processing of this grant request.
- ☐ I give consent to Hope Chest for Breast Cancer Foundation to disclose to the general public via television, radio stations, newspapers, websites, magazines, newsletters, social media, as well as in educational and fundraising opportunities my family's story (including diagnosis and general story provided in grant application) and any photo provided to Hope Chest. I understand my first name, city, state and hospital or care facility may be used.
- ☐ I understand that my personal information will not be published or shared with the public or a third party. Personal information is defined as home address, phone number, email address, and creditor information.

Applicant Signature: ____

Date: ______________________