Emergency Assistance Grant Application

Please read the following paragraph before completing the application:

1. To be eligible, you must be: (i) a resident of Minnesota; and (ii) in active treatment for breast cancer in the state of Minnesota (chemotherapy, hormone therapy in the metastatic setting or prior to surgery (neoadjuvant therapy), radiation, or surgery with a recovery time of more than four weeks). Hormone therapy after surgery (adjuvant therapy) and hospice care are not considered active treatment.

2. This application should take you between 5-10 minutes to complete.

3. Grant applications are considered and processed pursuant to Hope Chest Go's Support Guidelines, which are available online or a hard copy can be provided upon request for details.

4. Please have the first and last name, email address, and phone number of your Social Worker, Nurse Navigator, or Doctor. They will need to verify treatment before your grant application can be approved.

5. 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. You will need to provide a copy of the bill(s) you wish to be paid with this application.

Patient Information

First Name:_____Last Name: _____

Primary Address: _____

City:_____State:_____Zip Code: _____

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

Email Address: _____Birthdate:_____

How did you hear about Hope Chest for Breast Cancer Foundation? _____

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

If yes, approximately what date did you apply? _____

Gender *(please circle your answer)*: Male Female Prefer not to disclose

Ethnicity *(please circle your answer)*:

American Indian Asian or Pacific Islander Black or African American Caucasian

Hispanic or Latino Multiracial Prefer not to disclose

Do you have metastatic or Stage 4 disease? Please circle your answer. YES NO UNSURE

If you circled "UNSURE", is this recurrent disease? YES NO

Family Information

How many dependents live in the home? _____

Are you a single or dual-income household?_____

What is your annual household income?_____

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

- ☐ Travel 2+ hours for hospital/clinic visits
- ☐ Frequent clinic visits (2+ times/week)
- ☐ One or more inpatient hospitalizations in the past 90 days
- ☐ 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
- ☐ 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

Primary Hospital: _____

City:_____State:_____Zip Code: _____

Name of Oncology/Radiation Care Facility: _____

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:

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
  - ☐ Uber Gift 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: _____

MUST INCLUDE A COPY OF BILL WITH APPLICATION (on condition boxes checked aren't transportation or grocery)

Additional comments on the amount/type of request: _____

_____

_____

_____

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 would like to share my story, my breast cancer journey and how Hope Chest for Breast Cancer 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 Hope Chest for Breast Cancer Foundation's work in the community. Please include me on your newsletter and mailing distribution.

Applicant Signature: _____

Date: _____