FAMILY & PATIENT ASSISTANCE GRANT APPLICATION

The Beloved Foundation's Family and Patient Assistance Grant was developed as a short-term grant to assist with day to day living expenses for families and patients suffering a financial hardship as the result of a terminal cancer diagnosis. During this time money can be tight. This grant is intended to help reduce the stress and financial burden so that you can focus on spending quality time with one another. The grant can assist with rent/mortgage, food, utilities, gas/transportation, health insurance premiums, medical co-payments or prescriptions and burial/cremation expenses. We do not accept postmortem applications, however, if the patient passes away after an application was submitted, but before approval is granted, the family may still qualify for a one time/month assistance. Financial support is granted for a maximum of three months and $7500, not to exceed more than $3500 per month per applicant. Burial/cremation assistance will not exceed more than $550. Grant award amounts vary and are determined by the Board of Directors and contingent on available funds.

TO BE CONSIDERED FOR GRANT ASSISTANCE, YOU MUST:

- Provide fulltime in-home care to a loved one who has been diagnosed with terminal cancer and/or is under hospice care.
- Reside in San Bernardino or Riverside County
- Clearly demonstrate a financial burden due to cancer
- Be a first time Family & Patient Assistance Grant Applicant.

HOW TO APPLY:

- Please print clearly and provide full disclosure. Incomplete applications will not be processed
- Submit your completed application along with supporting documents (listed on the signature page)
- Have your hospice social worker or oncologist office provide a short referral on company letterhead

Once we receive your completed application, we may contact you and/or a social worker assigned to your loved one to schedule an interview with a Board Director. This interview simply provides us the opportunity to learn more about your story and determine how Beloved can best support you during this difficult time. After completing the interview, the Board of Directors will determine the type of support, length, and amount to be awarded. You will receive a letter explaining the Board's decision and if approved for support, the details of that support. All bills will be paid directly to the service provider on your behalf. Beloved may continue support up to two weeks after your loved one passes, at which time financial support will cease and you will be referred to a grief program/counselor to help you through the challenging transition ahead.

Please allow 2-3 weeks for the application to be processed.

YOUR INFORMATION

***Your information is kept confidential**

To be filled out by primary caregiver: Date: _____

If you are the patient and don't have a primary caregiver/contact, please put your information here as well as below for patient info.

Name: _____Last 4 digits of your Social Security #: _____Are you a U.S. Citizen*? Y / N
* Naturalized Citizens: Provide proof of residency (Copy of Resident card or U.S. Passport)

Phone number: _____ Best time to be reached via phone: AM PM

Mailing Address: _____
City/ State/ ZIP:
_____

Physical Address (if different from above): _____

Email Address: _____

Marital Status: _____ If Married, Spouse's Name: _____

Employer: _____Do you qualify for Paid Family Leave? _____

Employment Status (*Have you quit your job or taken a leave of absence to care for your loved one?)* _____

Are there any young children in the household or anyone else whom you are providing care for?

NAME	Relationship to you	AGE	Gender
			M/F
			M/F
			M/F
			M/F
			M/F

Patient Information:

Name of loved one on hospice/in-home care: _____

Relation: _____ Age: _____

Insurance Provider: _____ Is the patient receiving disability payments? _____

Oncologist: _____ Location of Cancer: _____

Stage of Cancer: _____

Hospice provider (if on Hospice): _____

Length of time under hospice/in-home care (to date):_____

Who referred you to Beloved Foundation?

- ☐ Social Worker (NAME) _____ PHONE _____
- ☐ Oncology Center (NAME) _____ PHONE_____
- ☐ FAMILY /FRIEND (NAME)_____PHONE _____
- ☐ INTERNET SEARCH
- ☐ SOCIAL MEDIA
- ☐ OTHER

Has this patient received a grant or any other form of assistance from Beloved Foundation? Yes_____ No_____
If you answered yes, please explain below what kind of assistance was received and when:

_____

_____

_____

If you are a non-English speaker, please provide the name and phone number of a relative or friend whom we may contact to translate. Please make sure that this person is also named on the HIPPA release form

NAME:_____ RELATIONSHIP TO PATIENT:_____

PHONE:_____ EMAIL:_____

Your Story

Please tell us a little about your circumstances.

Information to include present situation, and prognosis as well as type of support requesting, specific areas of need, etc. You may attach another page if necessary.

Your Needs

Please check any of the following areas of need:

- □ Medical Bills/ Copay
- □ Caregiving/respite care
- □ Counseling support
- □ Burial/ Cremation financial assistance
- □ Other (please specify): _____

Do you have any final arrangements already in place? _____

Please provide the name of the funeral home you have arrangements with: _____

If you are seeking financial assistance for final arrangements and have a written estimate or contract, please include a copy when you submit this application.

Your Household Budget per Month

Household Income

Salary/Wages (Net)	$_____
Child Support	$_____
Disability payments	$_____
Savings (include stocks and 401K)	$_____
Other _____	$_____
Total Income	**$_____**

(Please, provide copies of stubs for the listed income, you may black out social security numbers)

Expenses

Mortgage or Rent	$_____
Property taxes (if not included above)	$_____
Loan Payments (Example: Car, School)	$_____
Insurance	$_____
Utilities	$_____
Food	$_____
Clothing	$_____
Transportation Costs	$_____
Personal Care	$_____
Medical & Health Care	$_____
Entertainment	$_____
Education	$_____
Gifts/ Donations	$_____
Other: _____	$_____
Total Expenses	**$_____**
Amount of monthly support requesting:	$_____

Please **attach photocopies of the current monthly bills for which you are requesting assistance** from the Beloved Foundation. Please be advised, Beloved funds are not to be used for investment or entertainment purposes this includes cable TV bills.

Your Acknowledgement

I, the undersigned confirm the information provided is true to the best of my knowledge and that I am providing full time care for a loved one with stage 4 terminal cancer.

If this application is approved, funds provided by Beloved Foundation must be used solely for the purpose they were granted to me. For administrative purposes, organizations involved with my case may be contacted to verify the information I have provided on this application. I give permission for the Beloved Foundation to contact the service providers listed on the bills I am submitting on my behalf. I understand that the amount I may be granted will be based on my needs as well as available funds of the organization. I understand that I can file for additional grant money should the first grant term be exceeded and that there is no guarantee or promise that grant funds or services will be provided. I understand that Beloved has the right to discontinue support at any time and that if it is determined that grant funds were misused, I will be responsible for paying those funds back to the organization.

With your signature, you acknowledge and agree to the above.

_____

Signature Date

Your Submission

BEFORE YOU SUBMIT YOUR APPLICATION, please include the following documents:

- ☐ HIPPA RELEASE including patients signature
- ☐ Proof of income: paystubs, SDI, SSD and/ or SSI, most recent bank statement
- ☐ Proof of monthly mortgage or rent (for rent copy of check, money order, landlord receipt or lease agreement)
- ☐ Copies of any bills you are requesting this grant for
- ☐ Social Worker Referral Letter on Letterhead

For your convenience, you may submit this application via fax, email, or standard mail.

Fax: (909)801-2196 **Email:** belovedfoundation@ymail.com

Mail: Beloved Foundation
P.O. Box 766
Redlands, CA 92373

If you do not include copies of the bills you are requesting assistance with, it will delay the approval process. Your application will not be processed until all documentation has been received.

This Section to be filled out by Authorized Beloved Representative

Date Application Rec.: _____ Date Board Reviewed: _____
Application Determination: _____
Amount of funds Granted $ _____ Length of Grant _____
Other support services granted: _____

HIPAA Release of Information
AUTHORIZATION FORM

I, _____ hereby authorize the **Beloved Foundation** and its employees, affiliates, associates and volunteers, to release to or discuss with _____ my personal health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number) **except** the following information about me: **[describe information not to be disclosed, if any]**

_____

This release is for the sole purpose of helping me and my family to receive goods and/or services from the Beloved Foundation or one of its affiliates or agents.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my / my representative's signature below and shall expire 180 days after the date of signature below, or the date my coverage and arrangement ends with the **Beloved Foundation.**

I understand that I have a right to revoke this authorization by providing written notice to the Beloved Foundation. However, this authorization may not be revoked if the Beloved Foundation, its employees, affiliates, volunteers or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits that the Beloved Foundation may grant to me.

Name of Member/Patient: _____

Signature of Member: _____

Date: _____

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Members behalf with respect to this authorization form.

Name of Legal Representative: _____

Signature of Legal Representative: _____

Date: _____

Name of Witness: _____

Signature of Witness: _____