FAMILY & PATIENT ASSISTANCE GRANT APPLICATION

The Beloved Foundation's Family and Patient Assistance Grant was developed as short-term assistance towards 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 alleviate some financial burden so the patient can focus on spending quality time with loved ones. Our grant assistance can help with rent/mortgage, groceries, utilities, gas, 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 assistance. Burial/cremation assistance will not exceed more than $550. Grant amounts vary and are determined by the Board of Directors and are contingent on available funds.

TO BE CONSIDERED FOR GRANT ASSISTANCE, YOU MUST:

- Have a stage 4 cancer diagnosis or provide full time 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
- Complete our Grant Application and submit all requested materials to complete your file

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 as well as complete the Healthcare Provider Applicant Eligibility Checklist provided with this application

Once we receive your completed application, we may contact you and/or a social worker assigned to the patient to verify information. After application has been completed and accepted, the Board of Directors will determine the type of support, and amount to be granted. You will receive a letter explaining the Board's decision of approved or not approved for support, along with the details of that support. All bills will be paid directly to the service provider on your behalf.

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 or patient: Name: ____________________________ Date: _________________________

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: ____________________________

Employment Status *circle one*: EMPLOYED ON LEAVE RETIRED Do you qualify for Paid Family Leave? ___________

Last Date of Employment (if applicable):____

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

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:_______________________________________

Date of Diagnosis:___________________________________ 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

Have you (patient or primary caregiver) received a grant or any other form of assistance from Beloved Foundation in the past? 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:

- ☐ Rent
- ☐ Utilities
- ☐ 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) $__________________
SDI, SSD, and/or SSI $__________________
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 for.

Your Acknowledgement

By signing below, I confirm the information provided is true to the best of my knowledge and 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 for. 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 Beloved has the right to discontinue support at any time and 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 ensure you have included the following documents:

- ☐ HIPPA RELEASE including patients signature
- ☐ Proof of income: paystubs, SDI, SSD and/ or SSI, most recent bank statement and/or W-2 form
- ☐ 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
- ☐ Doctor/Oncologist Referral Letter on Letterhead
- ☐ Signed and Completed Beloved Healthcare Provider Applicant Eligibility Checklist (attached to this application)

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

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.

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: ____

Beloved Foundation Healthcare Provider Applicant Eligibility Checklist

Attached

Please detach this form from our application and return once completed by Healthcare Provider

Beloved Foundation Healthcare Provider Applicant Eligibility Checklist

Beloved Foundation
329 W State Street, Redlands, CA, 92373
Admin@belovedfoundation.com
Phone: 909-792-3191

Two Whom it May Concern,

This application is to be filled out by the patients Palliative Care Doctor or Nurse, Oncologist Doctor or Nurse, or Hospice Doctor or Nurse. This form is a mandatory component of their application for financial assistance.

The Beloved Foundation is an organization dedicated to offering financial assistance to families facing financial hardship due to a terminal cancer diagnosis, either through their own treatment or while caring for a loved one. To help us assess the applicant's eligibility for our grant program, we would greatly appreciate your assistance in providing the following information to be filled out on the following page:

1. **Disease and Treatment**: An overview of the applicant's diagnosis and treatment plan.

2. **Ability to Work and Financial Hardship**: Information on how the applicant's terminal diagnosis, cancer treatments, treatment-related side effects, and travel requirements impact their ability, or their caregiver's ability, to work or manage financial obligations. Specifically, we are attempting to assess and qualify the applicant to determine eligibility for the program.

3. **Grant Criteria**: Confirmation of whether the applicant meets the eligibility criteria for assistance from the Beloved Foundation, in alignment with our mission.

Your prompt response will greatly aid us in making an informed decision regarding the applicant's request for support. We truly appreciate your collaboration and ongoing dedication to supporting those in need.

Please feel free to reach out if you have any questions or require further information.

Thank you for your attention to this matter.

With Appreciation,

The Beloved Foundation

Beloved Foundation Healthcare Provider Applicant Eligibility Checklist

1. **Patient's Name: ____**

2. **Diagnosis (Cancer Type and Stage):________________________________**

3. **Date of Diagnosis:____**

4. **Treatment Plan Overview**

   Description of the patient's treatment plan, including details of current and planned therapies (e.g., surgery, radiation, chemotherapy, immunotherapy, targeted therapy, radiopharmaceuticals, or other treatments)

5. **Additional Medical Details**

   Symptoms, treatment-related side effects, treatment-related travel, functional status, who is caring for the patient

6. **Ability to Work and Financial Hardship**
   Is the patient retired or working? If they are working, is their cancer diagnosis causing them to be unable to work?

Healthcare Provider's Signature (and/or stamp):__________________________________

Phone number for any follow up: ____

Date:____________________