THE GIVING GARDEN FOUNDATION

"Cultivating advocacy for cancer patients residing in Gloucester & Mathews Virginia"

Financial Assistance Application

----------IMPORTANT INFORMATION! PLEASE READ!----------

The Giving Garden Foundation will provide financial assistance to cancer patients residing in Gloucester and Mathews Virginia. The amount of financial assistance provided will be on a case by case basis and dependent upon such factors as: how many dependants the patient has, patient's treatment center location and any other information we may deem necessary to process your request. Our mission is to be able to assist everyone, as we are aware that cancer treatment places undue burdens on every patient as well as their family.

Assistance provided may be for the following purposes:
Rents/Mortgage payment(s), Fuel Assistance (house and auto), Groceries (in the form of gift cards to your nearest grocer), Utilities (electric, phone, water, etc.), auto loan payment(s), medical treatments related to your cancer diagnosis, medical supplies, prescriptions and transportation to and from treatment.

Please be advised that by filing for assistance with TGGF you are also giving permission for us to contact your oncologist's office to confirm your diagnosis, plan of treatments and financial information. TGGF members are not medical professionals therefore we must rely on such persons to assist us in determining our plan of assistance for you. In addition we may choose to contact the lender, utility supplier, etc. for which you are seeking financial assistance for. When assistance is awarded, payments made by TGGF will be made directly to your treatment center, lien holder, utility company, etc. All information shared with TGGF will be held in the strictest of confidence.

_____ _____
Signing here signifies you have read and agree to the above terms **Date**

Name: (Full legal name)_____ **Date:** _____

SSN: _____ **DOB:** _____

Address: _____ **Length at address:** _____
(Mailing Address)

_____
(Physical Address)

Phone: _____ _____ _____
(Home) (Cell) (Best time to contact)

Email: _____

Diagnosis: _____ **Date of Diagnosis:** _____

Treatment Center: _____

Oncologist:_____ **Phone:** _____

Do you own or rent your home: _____ **Monthly payment:**_____

Name of landlord or mortgage company: _____
Payment Address:_____ **Phone:** _____

Do you own or are you financing your vehicle: _____ **Monthly payment:** _____
Name of lien holder: _____ **Phone:** _____
Vehicle make and model:_____

Number of Dependents Living in Your Home: _____ **Ages of Dependents: _____**

Emergency Contact person: _____ **Relationship: _____**

Phone: _____ **Alt. Phone: _____**

Name of Employer: _____
Supervisor's Name: _____ **Phone: _____**

Length of time at job: _____ **Monthly Income: _____**
Are you full time or part time: (FT) __ (PT) __ **Hours Per Week: _____**

Do you receive supplemental income? _____ If so, what/whom is the source? _____
Amount per month: _____

Name of Health Insurance Carrier: _____

Subscriber's Name: _____ **Relationship: _____**
Policy #: _____ **Group #: _____**

Address: _____ **Phone: _____**

Plan Type: _____ **Copay: _____** **Deductible:_____**

Name of Supplemental Insurance Carrier: _____

Address: _____ **Phone: _____**

Patient's estimated out of pocket expenses for prescriptions per month (RX relating to cancer treatment and other health conditions) $_____

Name of Pharmacy: _____ **Phone: _____**

Please list your current medications:

_____
_____
_____

What is your out of pocket expense for prescriptions per month?_____

Please explain what type of financial assistance you are seeking: (ie. rent/mortgage, utilities, fuel, groceries, medical treatment expenses, prescription assistance or medical supplies)

_____
_____
_____
_____
_____
_____
_____

Have you received financial assistance from any other organization in the last 12 months? (Y) ___ (N) ____
Name of financial assistance resource: _____
Amount Received: _____ Date Received: _____
Is/Was this a one time payment or ongoing assistance? _____
If ongoing, amount received and frequency: _____

Have you been turned down for financial assistance with any other organizations: (Y) ____ (N) _____

If you answered yes, please give the name of the organization for which you applied for assistance through: _____

Reason for denial of assistance: _____

By signing below you attest to the fact that you have provided the above information to the best of your knowledge and ability. Please be sure to file a Medical Consent Release form with your healthcare provider authorizing a TGGF Board of Director Member to confirm your medical information.

In order to process your request please send in the following documents along with this application. Failure to provide all requested information will result in the delay of processing your request for assistance. (Our goal is to process applications and award assistance within 30 days of receipt.)

Please check off the items below to ensure that you have included all necessary information with your application.

____ **Last 2 weeks of paycheck stubs**
____ **Copy of lease agreement or most recent Mortgage Statement**
____ **Copy of automotive lien agreement or payment voucher**
____ **Copy of last 3 utility bills (if you are applying for utility assistance)**

PLEASE MAIL ALL DOCUMENTS TO: The Giving Garden Foundation
ATTN: FAA
PO Box 1421
Hayes, VA 23072

FOR OFFICE USE ONLY:

Date received: _____
Diagnosis Information Verified: ____
Name of Contact at Treatment Facility: _____
Phone Number:_____

Financial Information Verified: ____
Current Balance at treatment facility: _____
D/I: _____

Does patient have insurance: (Y) _____ (N) _____

Comments:
_____
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