vickie's angel FOUNDATION

A TEMPORARY FINANCIAL BRIDGE FOR FAMILIES FIGHTING CANCER

Guidelines & Application for Financial Assistance

To apply for financial assistance, read carefully and complete the attached application.

Vickie's Angel Foundation's (VAF) Evaluation Committee meets every Tuesday to review new applications and to follow up with families currently being helped. Upon receipt of your application, a Vickie's Angel Foundation staff member will contact you with any questions and to confirm your availability to receive a phone call from our Evaluation Committee. During the Evaluation Committee phone call, you will be asked about your treatment and about your financial concerns for this month. Immediately after the discussion, the Evaluation Committee will determine if we can be a temporary financial bridge. Evaluation Committee calls will continue monthly until it is determined that a family is over our financial bridge.

To apply for financial assistance, you must meet the following criteria:

1. The applicant must have a cancer diagnosis and **BE IN ACTIVE TREATMENT** (chemotherapy, radiation, and/or surgery).
2. The applicant must own or rent a residence in one of the nine counties where Vickie's Angel Foundation provides assistance: Adams, Cumberland, Dauphin, Franklin, Lancaster, Lebanon, Perry, Schuylkill and York.
3. The applicant must be a U. S. citizen.
4. The applicant is unable to work and earn money to pay their non-medical expenses due to the effect cancer has made on their life.

Please be aware:

1. You will not be discriminated against or denied aid because of your race, age, religion, color, national origin, sex, political affiliation, or type of cancer.
2. Assistance depends on how cancer has affected the family's ability to pay their non-medical bills. If approved for assistance, funds are **paid directly to the vendor/service provider**. Please do not send us your bills.
3. We are a **temporary financial bridge** during a difficult time. We will work with families month-to-month to help them achieve a financial balance during cancer treatment. We cannot become long-term bill payers.
4. We **do not pay** medical bills, credit card bills, payments on personal loans, or taxes. We encourage you to work with the charity programs at your treatment facility to negotiate payments for medical expenses.
5. **All sections of the application must be complete and accurate** in order for Vickie's Angel Foundation to review the request. Failure to provide complete and truthful information is basis for denial.

Completed applications and any attachments can be mailed, faxed or emailed to:

Vickie's Angel Foundation
511 Bridge Street
P.O. Box 174
New Cumberland, PA 17070
Phone: 717-774-3800 **Fax:** 717-774-1802
Email: mickey@vawalk.org
www.vickiesangelfoundation.org

Did cancer cause a situation where you are unable to pay your bills?

Vickie's Angel Foundation may be able to help.

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

SECTION 1: Patient/Applicant Information

First Name _____ Last Name _____

Address _____ City_____ State_____ Zip_____

County: ☐ Adams ☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Lancaster ☐ Lebanon ☐ Perry ☐ Schuylkill ☐ York

U.S. Citizen: ☐ Yes ☐ No If the answer is No, you do not qualify for our assistance.

Phone Home (____) _____ Work (____) _____ Cell (____) _____

Email _____ Date of Birth _____/_____/_____ Age _____ ☐ Male ☐ Female

Emergency Contact Name _____ Emergency Phone (____) _____

☐ Single ☐ Live-In Significant Other ☐ Married ☐ Divorced ☐ Separated ☐ Widow/Widower

Spouse Name _____ Age _____

Total number of people in household _____ Number in household working _____

Number of dependent children in household _____ Names & ages of children _____

Number of children in college _____ _____

U.S. Veteran (Applicant/Spouse)? ☐ Yes ☐ No Branch _____ Length of service _____

Registered with VA? ☐ Yes ☐ No If Yes, type of benefits _____ Have you contacted VA for assistance? ☐ Yes ☐ No

If you do not speak English, please provide contact information of your interpreter. This person must be available when our Evaluation Committee member calls.

Name _____ Relationship _____

Phone (____) _____ Email _____

SECTION 2: Health Insurance Information

Does patient have health insurance? ☐ Yes ☐ No

If Yes, please indicate type of insurance: (Check all that apply)

☐ Private Insurance (through employer) ☐ VA Program ☐ Medicaid Pending ☐ Medicare + Supplement

☐ Charity Care ☐ Medicaid/Medical Assistance ☐ Medicare Only ☐ Medicare + Medicaid

Does your insurance cover prescriptions? ☐ Yes ☐ No

Primary Insurance Name _____ Supplemental Insurance Name _____

Annual Deductible Amount _____ Annual Out-of-Pocket Maximum Amount _____

Do you have ☐ Co-pays or ☐ Co-insurance? If yes, how much are they? _____

If employed, does your employer offer Family Medical Leave Act (FMLA) benefits? ☐ Yes ☐ No

If employed, does your employer provide ☐ Short- or ☐ Long-term Disability?

If No, why? _____

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

SECTION 3: Medical Information – WE MUST HAVE THIS INFORMATION TO HELP YOU.

This section must be completed by your oncologist, oncology nurse or social worker.

Name of patient _____ Date of diagnosis _____

Primary cancer diagnosis _____ Stage of cancer _____

New diagnosis Recurrence If recurrence, date _____

Is patient in active treatment? ☐ Yes ☐ No If yes, please indicate type of treatment: (Check all that apply)

Has treatment plan affected patient's ability to work? ☐ Full time ☐ Part time

☐ Chemotherapy ☐ Surgery ☐ Bone Marrow/Stem Cell Transplant ☐ Palliative Care

☐ Radiation ☐ Clinical Trial ☐ Hospice Care ☐ Immunotherapy

Treatment facility _____ Phone (____) _____

Nurse Navigator/Social Worker _____ Phone (____) _____

Doctor's plan of care (include chemotherapy details): _____

_____

_____

_____

_____

If not in active treatment, please indicate follow-up needed:

☐ Every 3 months ☐ Every 6 months ☐ Yearly ☐ Other _____

Name of oncologist (print)_____

Signature of MD_____ MD License# _____

Hospital/Clinic _____ Phone (____) _____

Address _____ City_____ State_____ Zip_____

Name/title of person completing this form (print) _____

☐ Oncologist ☐ Oncology RN ☐ Oncology Social Worker/Case Manager ☐ Nurse Navigator

Signature of person completing this form_____

Address _____ City_____ State_____ Zip_____

Phone (____) _____

Please mail, fax or email completed form to:

Vickie's Angel Foundation
511 Bridge Street
P.O. Box 174
New Cumberland, PA 17070
Fax: 717-774-1802
Phone: 717-774-3800
Email: mickey@vawalk.org
www.vickiesangelfoundation.org

Must be completed and signed by oncologist

BEFORE COMMITTEE CALLS YOU.

SECTION 4: Employment History – Complete for everyone in your household.

If you, your spouse, or others in household are currently unemployed, you must still complete any past work history.

PATIENT'S EMPLOYER _____ ☐ Self-employed

How many years at the current employer? _____ Date last worked _____ Salary then _____

If you've been at current employer for less than 2 years, please complete employment history for the past 3 years below:

EMPLOYER	DATES EMPLOYED (FROM ___TO ___)	TYPE OF WORK	TYPE OF WORK

Employment

When diagnosed were you: Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

After diagnosis you are: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

Has your diagnosis affected your ability to remain employed? ☐ Yes ☐ No

Disability

Have you applied for Social Security Disability ☐ Yes ☐ No If yes, what date? _____

Were you approved ? ☐ Yes ☐ No If yes, when did benefits start? _____ PLEASE PROVIDE A COPY OF THE APPROVAL.

What is your disability? _____

SPOUSE/SIGNIFICANT OTHER'S EMPLOYER _____ ☐ Self-employed

How many years at the current employer? _____ Date last worked _____

If you've been at current employer for less than 2 years, please complete employment history for the past 3 years below:

EMPLOYER	DATES EMPLOYED (FROM ___TO ___)	TYPE OF WORK	TYPE OF WORK

Employment

When diagnosed were you: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

After diagnosis you are: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

Has your diagnosis affected your ability to remain employed? ☐ Yes ☐ No

Disability

Have you applied for Social Security Disability ☐ Yes ☐ No If Yes, when? _____

Were you approved ? ☐ Yes ☐ No If Yes, when did benefits start? _____ Please provide a copy of the approval.

What is your disability? _____

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

OTHERS IN HOUSEHOLD _____ ☐ Not applicable

How many years at the current employer? _____ Date last worked _____ Salary then _____

If you've been at current employer for less than 2 years, please complete employment history for the past 3 years below:

EMPLOYER	DATES EMPLOYED (FROM ___TO ___)	TYPE OF WORK	TYPE OF WORK

Employment

When diagnosed were you: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

After diagnosis you are: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Retired ☐ Unemployed ☐ Disabled

Has your diagnosis affected your ability to remain employed? ☐ Yes ☐ No

Disability

Have you applied for Social Security Disability ☐ Yes ☐ No If Yes, when? _____

Were you approved ? ☐ Yes ☐ No If Yes, when did benefits start? _____ Please provide a copy of the approval.

What is your disability? _____

SECTION 5: Personal Statements

Briefly describe your financial situation **BEFORE** your cancer diagnosis:

_____

_____

_____

_____

Net Monthly Income Before Diagnosis: $_____

When did your treatment start: _____

Briefly describe **HOW CANCER HAS IMPACTED** your ability to pay your non-medical bills:

_____

_____

_____

_____

Net Monthly Income After Diagnosis: $_____

How did you learn of Vickie's Angel Foundation?

☐ Social Worker ☐ Doctor/Nurse ☐ Brochure ☐ Fundraising Event ☐ Newspaper/TV

☐ Facebook/Twitter ☐ Word of Mouth ☐ Other _____

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

SECTION 6: Current Household (Everyone) Income

If zero income, complete the Statement of Zero Income on page 7.

Applicant's current wages (NET) – Take Home $ _____/month
✓ Attach income tax form and recent pay stub

Spouse/Significant Other's current wages (NET) – Take Home $ _____/month
✓ Attach income tax form and recent pay stub

All Other Household Wage Earners' current wages (NET) – Take Home $ _____/month
✓ Attach income tax form and recent pay stub

Child Support and/or Alimony Self Other $ _____/month
✓ Attach copy showing monthly amount

Pension/401K Self Other $ _____/month
✓ Attach copy showing monthly amount

Social Security Self Other $ _____/month
✓ Attach copy showing monthly amount

Social Security Disability (SSD) Self Other $ _____/month
✓ Attach copy showing monthly amount

Supplemental Security Income (SSI) Self Other $ _____/month
✓ Attach copy showing monthly amount

Unemployment Compensation Self Other Start date _____ End date _____ $ _____/month
✓ Attach copy showing monthly amount

Public Assistance (TANF, SNAP, Food Stamps, etc.) Self Other $ _____/month

Short/Long- Term Disability Self Other $ _____/month
✓ Attach copy showing monthly amount

Family/Friend Financial Support $ _____/month

ASSISTANCE FROM OTHER ORGANIZATIONS, Please list names $ _____/month

_____

_____

_____

Total Monthly Net Income CURRENTLY **$ _____/month**

Filed Tax Return ☐ Yes ☐ No

ACCOUNT BALANCES **Please complete each section**

Checking Account $ _____
Savings Account $ _____
Investments (401K, CDs, Money Market, Stocks/Bonds) $ _____
Life Insurance Cash Value $ _____
Other (please describe) _____ $ _____

Must be complete.

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

STATEMENT OF ZERO INCOME – IF APPLICABLE

I, _____ state that no member of my household has received any source of income
NAME
during the past thirty (30) days. Our household has been without income since _____.
DATE
I hope and expect to receive some income on or about _____ from
DATE
_____.
LIST WHERE INCOME WILL COME FROM

During the above period, how did your family meet their household needs for:

Food

_____

_____

_____

Shelter (i.e. housing, heat, electricity)

_____

_____

_____

Living Expenses (i.e. medical bills, car expenses, clothing)

_____

_____

_____

I understand that I can be denied help from Vickie's Angel Foundation for making false statements, and I do agree that the answers provided are complete and truthful to the best of my knowledge.

Applicant's signature: _____ Date: _____

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

SECTION 7: Household (Everyone) Expenses

	Monthly Amount	Are you current? Y or N	If Not, Total Amount Owed	Due Date
Housing				
Mortgage				
Rent				
Lot Rent				
Family				
Groceries				
Child Care				
Child Support				
Utilities				
Electric				
Oil/Gas				
Water/Sewer				
Trash				
Other				
Transportation				
Gas, Tolls				
Car Payment – Vehicle 1				
Car Payment – Vehicle 2				
Car Insurance Premiums				
Communication				
Cell Phone				
Home Phone				
Cable				
Internet				
Miscellaneous*				
Loans (list each)				
Fine and Penalties				
Required				
Health Insurance Premiums				
Copays/Coinsurance/Treatments				
Total Out-of-Pocket Medical				

Total Monthly	**$** _____	**$** _____

*If additional room is needed, add a sheet listing credit cards and/or loans.

You must complete this section.	**Before Cancer Treatment**	**After Cancer Treatment/Currently**
Total Monthly Net Income	$	$
Total Monthly Medical Expenses	$	$
Total Monthly Other Expenses	$	$
Difference	$	$

Please list the top 3 most important expenses that you would like VAF to consider offering financial assistance.
VAF considers assistance for **non-medical expenses only. We do not pay medical bills, taxes, or credit cards. VAF focuses on paying rent/mortgages, utilities, auto payments, auto insurance, and providing gift cards for gas and groceries. This allows you to have additional funds available to pay your medical bills. Do not submit your bills to us at this time.**

#1_____ **#2**_____ **#3**_____

ALL SECTIONS MUST BE COMPLETE AND ACCURATE TO BE CONSIDERED FOR ASSISTANCE.

SECTION 8: Affirmation/Consent to Release Information for you to sign.

I do hereby authorize all hospitals, financial institutions and insurance groups to release to Vickie's Angel Foundation, or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance. I further authorize Vickie's Angel Foundation and its representatives to provide such information to those institutions as may be reasonably required to assist our family. All consents given herein shall continue until such time as the undersigned provides notice of termination in writing.

As an inducement to Vickie's Angel Foundation, a non-profit organization, to advance supplemental family support expenses in conjunction with the medical treatment of cancer for _____ undersigned to hereby affirm as follows:
PATIENT

- ☐ I understand Vickie's Angel Foundation is a temporary financial bridge during a difficult time.
- ☐ The term "non-medical expenses" is understood to mean those reasonable and necessary expenses incurred by the family of the above-named in conjunction with that patient receiving medical treatment for cancer. Financial assistance will be provided, with the use of said funds to be specified by Vickie's Angel Foundation.
- ☐ If approved for assistance, funds are paid directly to the vendor/service provider.
- ☐ The undersigned agrees to return within 30 days any equipment provided by Vickie's Angel Foundation that is no longer needed by this patient, so that equipment can be utilized to benefit other families.
- ☐ Periodic medical updates may be required from the applicant's medical team.
- ☐ Vickie's Angel Foundation will pursue restitution for grants if it is determined that the information submitted on the application is false.
- ☐ I have read the Guidelines for Financial Assistance on page 1.
- ☐ I declare that the information furnished on this application form, including attached documents, is true and correct to the best of my knowledge.
- ☐ I give permission for members of Vickie's Angel Foundation's Family Evaluation Committee to review all information provided on and with this application, understanding that all information and documentation is confidential and for use solely in consideration of my request for financial assistance from Vickie's Angel Foundation.

Dated this _____ day of _____ in the year _____

Patient Name (print) _____ Spouse Name (print) _____

Patient Signature _____ Spouse Signature _____

SECTION 9: Checklist – Important

Complete the following checklist and attach it to your application or it will be denied.

- ☐ Attach all **PROOF OF INCOME** including copies of:
  - ☐ Income Tax Forms (if you pay)
  - ☐ Current Pay Stubs
  - ☐ Social Security/Disability Statements
  - ☐ Pension/401K Disbursements
  - ☐ Child Support Disbursements
  - ☐ Any other documents detailing financial assistance that the patient or family members receive from the government or from any other charitable organizations.
- ☐ Attach **PROOF OF ASSETS** in the form of copies of your last 2 month's bank statement.
- ☐ SECTION 3, PAGE 3: Medical Information must be completed and signed by your physician.

All of these documents are required to be submitted with application.