AICAF and Angel Foundation Financial Assistance Form

The American Indian Cancer Foundation (AICAF) in partnership with Angel Foundation, are pleased to provide relief funds for Indigenous cancer survivors residing or receiving treatment in Minnesota who are in active cancer treatment. AICAF will provide $500 to each individual in the form of Walmart or Target gift cards, or a pre-approved gas station fuel card to help offset lost income or additional expenses.

Applicants will submit a brief funding request. AICAF staff will review and update applicants based on available funds. We are grateful to support you. Please contact AICAF with any questions at health@aicaf.org.

* Required

1. Email *

<table>
<thead>
<tr>
<th>Eligibility Requirements:</th>
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<tbody>
<tr>
<td>1. Identify as American Indian/Alaska Native/Native Hawaiian</td>
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<td>2. Must have a cancer diagnosis and be in cancer treatment</td>
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<td>3. Must be 18 years of age or older</td>
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<td>4. Must reside and/or be receiving treatment in Minnesota</td>
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Selection Criteria
Applications will be reviewed by the AICAF survivor support staff committee. Funds will be disseminated on a nondiscriminatory basis until depleted.

Part of the application process includes the completion of a Medical Information Form by a member of your oncology treatment team. This individual may be a social worker, nurse, navigator or doctor. An AICAF team member will follow up after submitting this application.

**Please complete all required questions below to be considered. If non-applicable please input N/A**
2. Full Name (First and Last) *

__________________________________________

3. Email: *

__________________________________________

4. Phone Number

__________________________________________

5. Full Mailing Address: (Street, City, State, Zip) *

__________________________________________

__________________________________________

__________________________________________

6. Tribal Affiliation: *

__________________________________________

7. Gender: *

Check all that apply.

☐ Female
☐ Male
☐ Two-Spirit
☐ Prefer not to say
☐ Other: __________________________

Other: __________________________
8. What year were you born? *

9. What is your cancer diagnosis? *

10. Are you in active treatment for cancer? *

   Check all that apply.
   
   □ Yes
   □ No

11. What kind of treatment are you receiving? *

12. Where are you receiving your treatment? *

13. Which retailer would you prefer for your financial assistance?

   Mark only one oval.
   
   □ Walmart
   □ Target
   □ Gas Station **AICAF staff will contact you for further information if you select this option.**
14. Would you like to share your cancer story with someone at AICAF? (Optional)

*Mark only one oval.*

- [ ] Yes
- [ ] No

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Google Forms
American Indian Cancer Society / Angel Foundation  
Cancer Survivor Financial Assistance Program  
Cancer Verification Form

Provider: Please complete the following form and return to sblackhall@aicaf.org by 6/30/22. Please reach out with any questions.

Section 1-

Type of Cancer Diagnosis
__________________________________________________________________________

Stage
__________________________________________________________________________

Section 2-

Current Treatment (please check all that apply):

Chemotherapy Date of last (or next) treatment _________________________________

Radiation Date of last (or next) treatment _________________________________

Immunotherapy Date of last (or next) treatment ____________________________

Hormone Therapy Date of last (or next) treatment __________________________

Bone Marrow Transplant Date of transplant _________________________________

Surgery Date of surgery _________________________________________________

Will the patient’s recovery from surgery take at least four weeks?

___ Yes ___No

Palliative Care Date entered ______________________________________________

Hospice Date entered _____________________________________________________

Other Type of Care (s) and Date (s) ________________________________________
Section 3- Clinic Information

Clinic Name_______________________________________________
Street Address ____________________________________________
Suite __________________
City _____________________________________________________
County __________________________________________________
State _____________ Zip__________________
Oncologist/ Provider Name (Print) _______________________________________________
Oncologist/ Provider Name (Signature) __________________________________________
Date ______________ Phone ____________________________________
I hope this message finds you well.

Thank you for applying to the cancer survivor financial assistance program. As a part of our ongoing funder compliance requirements, AICAF will need supporting documentation stating that the applicant is currently undergoing active cancer treatment. Please have your provider complete the attached document and submit it to Samantha Blackhall at sblackhall@aicaf.org by Friday, January 21st, 2022. If you are unable to meet that deadline, please reach out so we can discuss alternative methods of getting that information. Once reviewed, we will reach out with eligibility status.

Thank you,