Help when cancer strikes

angel foundation™

ONE APPLICATION

- Emergency Financial Assistance Grant
- Financial Cancer Care Program
- Adult & Family Programs

Application Requirements

- Patient completes **all sections** and signs the application.
- A member of your oncology care team completes and signs the Medical Information Form.

THREE WAYS TO COMPLETE APPLICATION

1. Complete printed copy and return in-person or via email to:
   Angel Foundation
   1155 Centre Pointe Dr., Ste. 7
   Mendota Heights, MN 55120
   or you can email it to
   grants@mnangel.org
2. To apply online, please visit **mnangel.org**
3. Scan this QR code

Program Information

Emergency Financial Assistance (EFA) Grant

EFA supports adult cancer patients by relieving some of their non-medical living expenses.

- Patient is 18 years of age or older.
- Patient is in active treatment** for cancer.
- Patient meets financial guidelines set by Angel Foundation™.
- Patient is living in - or receiving cancer treatment in - the following fourteen Minnesota or Wisconsin Counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Olmsted, Ramsey, Scott, Sherburne, St. Croix (WI), St. Louis, Washington, and Wright.

**Treatment includes one or more of the following:

- Chemotherapy
- Clinical trials
- Hormone therapy
- Hospice
- Immunotherapy
- Palliative care
- Radiation
- Transplant
- Surgery
- Other treatment per healthcare provider

Financial Cancer Care (FCC) Program

Designed to help patients impacted by cancer manage finances through virtual workshops and one-on-one planning with a Certified Financial Planner™ (CFP©).

For patient or family member to register for the FCC Workshop

- Patient is 18 years of age or older.
- Patient is living in - or receiving cancer treatment in - in one of the fourteen Minnesota Counties listed above.
- Patient has received treatment** for cancer within the last 2 years.

To meet one-on-one with a CFP©

- Patient meets all the FCC Workshop criteria.
- Patient is financially independent.
- Patient is not currently working with a Financial Planner.

Adult & Family Programs (AFP)

Provides a variety of free, adult and kid-friendly activities and resources to initiate conversations about what cancer is, how it impacts a family, and encourages healthy communication and coping skills.

For Monthly Programs

- Anytime after a cancer diagnosis.

Angel Packs™

- Fun and educational packs for children ages 4 to 18 who have a loved one with cancer.
- Kid pack: Ages 4-8, Preteen pack: Ages 9-12, Teen pack: Ages 13-18.

Patient Information *Required

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Who is filling out the application?*

- ☐ I am the patient, applying for myself.
- ☐ I am an oncology healthcare professional assisting the patient.
- ☐ I am assisting the patient and will indicate my relationship below.

Your name: ______________________ Relationship to patient: ______________________

I am applying for:*
- ☐ Emergency Financial Assistance (EFA) Grant
- ☐ Financial Cancer Care (FCC) Program
- ☐ Adult & Family Programs (AFP)

What is the main reason Emergency Financial Assistance would be helpful?*

- ☐ Cannot work due to treatment
- ☐ Extreme circumstances
- ☐ Forced to move/homelessness
- ☐ Has young children
- ☐ High medical costs
- ☐ In school/recently finished
- ☐ Increasing expenses due to treatment
- ☐ Lost job
- ☐ Terminal
- ☐ Not applying for Emergency Financial Assistance

What is the main reason you are interested in the Financial Cancer Care Program?*

- ☐ Consult on investments
- ☐ Create a new budget
- ☐ Create new financial goals
- ☐ Increase financial confidence
- ☐ Other: (please specify) ______________________
- ☐ Not applying for Financial Cancer Care

How would you like to participate in Adult & Family Programs?*

- ☐ Angel Pack™ Program
- ☐ Social & education programs
- ☐ Both the Angel Pack™ Program and social & educational programs
- ☐ Not applying for Adult & Family Programs

First Name* ______________ Middle Initial ______ Last Name* ______________

Preferred Name ______________________ Birthdate* (MM/DD/YYYY) ____/_____/______

Street Address* ______________________ Apt # __________

City* ______________ State* ______ Zip* __________ County* __________

Phone/Mobile* ______________________ Email* ______________________

Please list others we can discuss your application with besides your oncology team:

____

____

Would you like Angel Foundation™ to contact you regarding other community resources?
- ☐ Yes
- ☐ No

If yes, how would you like to be contacted?

____

How would you like to be contacted about your application?*
- ☐ Email
- ☐ Letter

May we leave a message on your phone?*
- ☐ Yes
- ☐ No

Do you need language translation?
- ☐ Yes
- ☐ No

If yes, what language? ______________________

Demographic Information

Your responses to the following questions enable Angel Foundation™ to better serve communities equitably. All responses are kept private and secured and will not be used for discriminatory purposes.

What gender do you identify as?*

- [ ] Female
- [ ] Male
- [ ] Non-Binary
- [ ] Two-Spirit
- [ ] Prefer not to answer
- [ ] Other (Please Specify)

Have you participated in active duty in the military?*

- [ ] Yes
- [ ] No
- [ ] Prefer not to answer

What race, ethnicity, or tribal affiliation do you identify with?*

- [ ] American Indian or Native Alaskan
- [ ] Asian, Native Hawaiian, or Pacific Islander
- [ ] Black or African American
- [ ] Hispanic, Latina/o/x Spanish origin
- [ ] Middle Eastern or North African
- Non-Hispanic White
- [ ] Two or More Races
- [ ] Prefer not to answer
- [ ] Tribal Affiliation (Please specify) ______________________
- [ ] Other (Please specify)

Marital Status*

- [ ] Divorced
- [ ] Married
- [ ] Partnership
- [ ] Separated
- [ ] Single
- [ ] Widowed
- [ ] Prefer not to answer

Medical Information

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Cancer Diagnosis:* ______________________

Cancer Stage*

- [ ] I
- [ ] II
- [ ] III
- [ ] IV
- [ ] O
- [ ] None Specified
- [ ] Remission
- [ ] Recurrent

Clinic/Hospital Name* ______________________

City* ______________________

Oncologist Name* ______________________

Household Information

Please list the total number of people living in your household including yourself* ______________________

Do you have school-aged children in your household (ages 4-18)?*

- [ ] Yes
- [ ] No

What is your housing situation?*

- [ ] Stable
- [ ] Unstable
- [ ] Prefer not to

Employer ______________________

Medical Insurance Provider ______________________

Total Net Monthly Household Income (after taxes)* ______________________

Additional Information

How did you hear about Angel Foundation™?*

- [ ] Community Health Worker
- [ ] Community Organization (please specify) ______________________
- [ ] Doctor
- [ ] Friend/Relative
- [ ] Internet
- [ ] Nurse
- [ ] Patient Counselor/Navigator
- [ ] Social Worker

May we add you to our mailing list?*

- [ ] Yes
- [ ] No

Will you be willing to share your story with our community?*

- [ ] Yes
- [ ] No

This is not required to receive assistance. If you choose yes, someone from Angel Foundation™ may contact you.

Please tell us anything else you would like us to know:

____

____

____

____

____

____

- [ ] Please check here to be contacted about your situation.

Patient Release

- [ ] I declare the information on this application is true and correct to the best of my knowledge. I understand that each application is reviewed on a case-by-case basis, and the final decision will be made by Angel Foundation™. I hereby give my permission that this application and all information offered can be provided to Angel Foundation™ and discussed with my healthcare professional. I understand that all information reviewed is confidential.

Signature* ______________________ Date of Signature* _____/_____/_______

1155 Centre Pointe Drive, Suite 7 | Mendota Heights, MN 55120 | P: (612) 627-9000 | F: (612) 338-3018 | mnangel.org