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

Help when cancer strikes angel foundation

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

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* _____/_____/_____