Program Information

Emergency Financial Assistance (EFA) Grant
EFA supports adult cancer patients by relieving some of their non-medical living expenses.

- Patient completes all sections and signs the application.
- A member of your oncology care team completes and signs the Medical Information Form.
- 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 twelve Minnesota Counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, 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 twelve 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.

Application Requirements

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1. Complete printed copy and return in-person or via email to: Angel Foundation 1155 Centre Pointe Dr., Ste. 7 Medota 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
Patient Information *Required

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)

Medical Information

Cancer Diagnosis:* _______________________________

Cancer Stage*
- □ I
- □ II
- □ III
- □ IV
- □ 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?*
- Yes
- No
- Stable
- Unstable
- Prefer not to answer

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.

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