

1
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.

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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
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



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 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 backpacks for children 18 and under who have a loved one with cancer.
- Kid pack: Ages 5-8, Preteen pack: Ages 9-12, Teen pack: Ages 13-18.

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 ProgramTM
- Social & education programs
- Both the Angel PackTM 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 III O Remission
 II IV None Specified 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 5-18)?*

- Yes No

What is your housing situation?*

- 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 Friend/Relative
 Community Organization Internet
 (please specify) _____ Nurse
 Doctor 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.

Demographic Information

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* ____/____/____