



THE GIVING GARDEN FOUNDATION

“Cultivating advocacy for cancer patients residing in Gloucester & Mathews Virginia”

Financial Assistance Application

-----IMPORTANT INFORMATION! PLEASE READ!-----

The Giving Garden Foundation will provide financial assistance to cancer patients residing in Gloucester and Mathews Virginia. The amount of financial assistance provided will be on a case by case basis and dependent upon such factors as: how many dependants the patient has, patient’s treatment center location and any other information we may deem necessary to process your request. Our mission is to be able to assist everyone, as we are aware that cancer treatment places undue burdens on every patient as well as their family.

Assistance provided may be for the following purposes:

Rents/Mortgage payment(s), Fuel Assistance (house and auto), Groceries (in the form of gift cards to your nearest grocer), Utilities (electric, phone, water, etc.), auto loan payment(s), medical treatments related to your cancer diagnosis, medical supplies, prescriptions and transportation to and from treatment.

Please be advised that by filing for assistance with TGGF you are also giving permission for us to contact your oncologist’s office to confirm your diagnosis, plan of treatments and financial information. TGGF members are not medical professionals therefore we must rely on such persons to assist us in determining our plan of assistance for you. In addition we may choose to contact the lender, utility supplier, etc. for which you are seeking financial assistance for. When assistance is awarded, payments made by TGGF will be made directly to your treatment center, lien holder, utility company, etc. All information shared with TGGF will be held in the strictest of confidence.

Signing here signifies you have read and agree to the above terms

Date

Name: (Full legal name) _____

Date: _____

SSN: _____ DOB: _____

Address: _____
(Mailing Address)

Length at address: _____

(Physical Address)

Phone: _____
(Home) (Cell) (Best time to contact)

Email: _____

Diagnosis: _____ Date of Diagnosis: _____

Treatment Center: _____

Oncologist: _____ Phone: _____

Do you own or rent your home: _____ Monthly payment: _____

Name of landlord or mortgage company: _____
Payment Address: _____ Phone: _____

Do you own or are you financing your vehicle: _____ Monthly payment: _____
Name of lien holder: _____ Phone: _____
Vehicle make and model: _____

Number of Dependents Living in Your Home: _____ Ages of Dependents: _____

Emergency Contact person: _____ Relationship: _____

Phone: _____ Alt. Phone: _____

Name of Employer: _____

Supervisor's Name: _____ Phone: _____

Length of time at job: _____ Monthly Income: _____

Are you full time or part time: (FT) __ (PT) __ Hours Per Week: _____

Do you receive supplemental income? _____ If so, what/whom is the source? _____

Amount per month: _____

Name of Health Insurance Carrier: _____

Subscriber's Name: _____ Relationship: _____

Policy #: _____ Group #: _____

Address: _____ Phone: _____

Plan Type: _____ Copay: _____ Deductible: _____

Name of Supplemental Insurance Carrier: _____

Address: _____ Phone: _____

Patient's estimated out of pocket expenses for prescriptions per month (RX relating to cancer treatment and other health conditions) \$ _____

Name of Pharmacy: _____ Phone: _____

Please list your current medications:

What is your out of pocket expense for prescriptions per month? _____

Please explain what type of financial assistance you are seeking: (ie. rent/mortgage, utilities, fuel, groceries, medical treatment expenses, prescription assistance or medical supplies)

Have you received financial assistance from any other organization in the last 12 months? (Y) ___ (N) ___

Name of financial assistance resource: _____

Amount Received: _____ Date Received: _____

Is/Was this a one time payment or ongoing assistance? _____

If ongoing, amount received and frequency: _____

Have you been turned down for financial assistance with any other organizations: (Y) ___ (N) ___

If you answered yes, please give the name of the organization for which you applied for assistance through: _____

Reason for denial of assistance: _____

By signing below you attest to the fact that you have provided the above information to the best of your knowledge and ability. Please be sure to file a Medical Consent Release form with your healthcare provider authorizing a TGGF Board of Director Member to confirm your medical information.

In order to process your request please send in the following documents along with this application. Failure to provide all requested information will result in the delay of processing your request for assistance. (Our goal is to process applications and award assistance within 30 days of receipt.)

Please check off the items below to ensure that you have included all necessary information with your application.

- Last 2 weeks of paycheck stubs**
- Copy of lease agreement or most recent Mortgage Statement**
- Copy of automotive lien agreement or payment voucher**
- Copy of last 3 utility bills (if you are applying for utility assistance)**

PLEASE MAIL ALL DOCUMENTS TO: The Giving Garden Foundation
ATTN: FAA
PO Box 1421
Hayes, VA 23072

FOR OFFICE USE ONLY:

Date received: _____
Diagnosis Information Verified: _____
Name of Contact at Treatment Facility: _____
Phone Number: _____

Financial Information Verified: _____
Current Balance at treatment facility: _____
D/I: _____

Does patient have insurance: (Y) _____ (N) _____

Comments:
