FAMILY & PATIENT ASSISTANCE GRANT APPLICATION

The Beloved Foundation's Family and Patient Assistance Grant was developed as a short term grant to assist with day to day living expenses for families and patients suffering a financial crisis as a result of a terminal cancer diagnosis. During this time money can be tight so this grant is intended to help reduce the stress and financial burden so that you can focus on spending quality time with one another. The grant can assist you with rent/mortgage, food, utilities, gas/transportation, health insurance premiums, medical co-payments or prescriptions and burial/cremation expenses up to $2500.

TO BE CONSIDERED FOR GRANT ASSISTANCE , YOU MUST:

- Be providing fulltime in home care to a loved one who has been diagnosed with terminal cancer and is under hospice care.
- Live in San Bernardino or Riverside County
- Clearly demonstrate financial burden due to cancer
- Have not received this same grant previously

HOW TO APPLY:

- Please print clearly and provide full disclosure. Incomplete applications will not be processed
- Submit your completed application along with supporting documents (listed on the signature page)
- Have your hospice social worker provide a short referral on company letterhead

Please allow 3-4 weeks for the application to be processed. Each application is evaluated with care. we take time to see how we can best help.

YOUR INFORMATION

***your information is kept private**

To be filled out by primary caregiver: Date:_____

Name: _____Last 4 digits of your Social Security #: _____Are you a U.S. Citizen*? Y / N
* Naturalized Citizens: Provide proof of residency (Copy of Resident card or U.S. Passport)

Phone number:_____ Best time to be reached via phone: AM PM

Mailing Address: _____
City/ State/ ZIP:
_____

Physical Address (if different from above): _____

Email Address: _____

Marital Status: _____ If Married, Spouse's Name: _____

Employer: _____Do you qualify for Paid Family Leave ? _____

Employment Status (*Have you quit your job or taken a leave of absence to care for your loved one?)* _____

Name: _____

Are there any young children in the household or anyone else whom you are providing care for?

NAME	Relationship to you	AGE	Gender
			M/F
			M/F
			M/F
			M/F
			M/F

Your Loved One:

Name of loved one on hospice care: _____

Relation: _____ Age: _____

Insurance Provider: _____ Is the patient receiving disability payments? _____

Oncologist: _____ Location of Cancer: _____

Stage of Cancer: _____

Hospice provider (if on Hospice): _____

Length of time under hospice care (to date):_____

Who referred you to Beloved Foundation?

- ☐ Social Worker (NAME) _____ PHONE _____
- ☐ Oncology Center (NAME) _____ PHONE_____
- ☐ FAMILY /FRIEND (NAME)_____PHONE _____
- ☐ INTERNET SEARCH
- ☐ SOCIAL MEDIA
- ☐ OTHER _____

If you are a non-English speaker, please provide the name and phone number of a relative or friend whom we may contact to translate. Please make sure that this person is also named on the HIPPA release form

NAME:_____ RELATIONSHIP TO PATIENT:_____

PHONE:_____ EMAIL:_____

Your Story

Please tell us a little about your circumstances.

Information to include: present situation, and prognosis as well as type of support requesting, specific areas of need, etc. You may attach another page if necessary.

Your Needs

Please check any of the following areas of need:

- ☐ Medical Bills/ Copay
- ☐ Caregiving/respite care
- ☐ Counseling support
- ☐ Burial/ Cremation financial assistance
- ☐ Other (please specify): _____

Do you have any final arrangements already in place? _____

Please provide the name of the funeral home you have arrangements with: _____

If you are seeking financial assistance for final arrangements and have a written estimate or contract, please include a copy when you submit this application.

Our Organization

It may take 3-4 weeks for your application to be processed. Financial support is granted for a maximum of 3 months contingent on available funds. The Beloved Board of Directors will determine the amount of funds granted which may or may not be the same amount as requested by the applicant and will not exceed more than $2500.00 per month per application. Burial/cremation assistance will not exceed more than $850.00. Should you be approved you will be notified in writing of the determination and your approved bills will be paid to the service providers on your behalf. Beloved may continue support up until two (2) weeks after your loved one passes, at which time financial support will cease and you will be referred to a grief program or grief counselor to help ease you through the difficult transitions ahead.

Your Household Budget per Month

Household Income

Salary/Wages (Net)	$_____
Child Support	$_____
Disability payments	$_____
Savings (include stocks and 401K)	$_____
Other _____	$_____
Total Income	**$_____**

(Please, provide copies of stubs for the listed income, you may black out social security numbers)

Expenses

Mortgage or Rent	$_____
Property taxes (if not included above)	$_____
Loan Payments (Example: Car, School)	$_____
Insurance	$_____
Utilities	$_____
Food	$_____
Clothing	$_____
Transportation Costs	$_____
Personal Care	$_____
Medical & Health Care	$_____
Entertainment	$_____
Education	$_____
Gifts/ Donations	$_____
Other: _____	$_____
Total Expenses	**$_____**
Amount of monthly support requesting:	$_____

Please **attach photocopies of the current monthly bills for which you are requesting assistance** from the Beloved Foundation. Please be advised, Beloved funds are not to be used for investment or entertainment purposes this includes cable TV bills.

Your Acknowledgement

I, the undersigned confirm the information provided is true to the best of my knowledge and that I am providing full time care for a loved one with stage 4 terminal cancer.

If this application is approved, funds provided by Beloved Foundation must be used solely for the purpose they were granted to me. For administrative purposes, organizations involved with my case may be contacted to verify the information I have provided on this application. I give permission for the Beloved Foundation to contact the service providers listed on the bills I am submitting on my behalf. I understand that the amount I may be granted will be based on my needs as well as available funds of the organization. I understand I have the opportunity to file for additional grant money should the first grant term be exceeded and that there is no guarantee or promise that grant funds or services will be provided. I understand that Beloved has the right to discontinue support at any time and that if it is determined that Grant monies were misused I will be responsible for paying those funds back to the organization.

With your signature, you acknowledge and agree to the above.

_____

Signature Date

Your Submission

BEFORE YOU SUBMIT YOUR APPLICATION, please include the following documents:

- ☐ HIPPA RELEASE including patients signature
- ☐ Proof of income: paystubs, SDI, SSD and/ or SSI
- ☐ Proof of monthly mortgage or rent (for rent copy of check, money order, landlord receipt or lease agreement)
- ☐ Copies of any bills you are requesting this grant for
- ☐ Social Worker Referral Letter on Letterhead

For your convenience, you may submit this application via fax, email or standard mail.

Fax: (909)801-2196 **Email:** belovedfoundation@ymail.com

Mail: Beloved Foundation
329 W. State St.
Redlands, CA 92373

If you do not include copies of the bills you are requesting assistance with, it will delay the approval process. Your application will not be processed until all documentation has been received.

This Section to be filled out by Authorized Beloved Representative

Date Application Rec.: _____ Date Board Reviewed: _____
Application Determination: _____
Amount of funds Granted $ _____ Length of Grant _____
Other support services granted: _____