



Application for Financial Assistance

47496 Greenbriar Lane Macomb, MI 48044
 Phone: (586)291-9496 Fax: (586)569-2511

All applications are kept confidential. Angels of Hope cannot meet every request. However, some assistance is generally available. Families may be prioritized by need, but no family will be ineligible because of their income level. Angels of Hope reserves the right and the Applicant hereby grants permission to share all information provided by the applicant to third parties on an as-needed basis.

Section 1 – Patient Information

Name (First, Middle, Last)		Diagnosis	Date of Birth	
Address (Street or PO Box, City, State, Zip)			Age	Gender
Hospital:	Oncologist:	Social Worker:		Date Submitted:

Section 2 – Parent/Guardian Information

MOTHER/GUARDIAN INFORMATION			
Mother's/Guardian's Name	Primary Phone:	Home Cell	
	Alternate Phone:	Home Cell	
Employment (employer and nature of work/title):	Email:		Gross Monthly Income \$
FATHER/GUARDIAN INFORMATION			
Father's/Guardian's Name	Primary Phone:	Home Cell	
	Alternate Phone:	Home Cell	
Employment (employer and nature of work/title):	Email:		Gross Monthly Income \$

Does patient or family receive assistance from other agencies and or foundation(s)? If so, list agencies/foundation(s) and nature of assistance:

How were you referred to Angels of Hope?
 Social Worker/Hospital Staff Website Another Assisted Family Other (Explain)

Section 3 – Need Evaluation

PLEASE PRIORITIZE YOUR FAMILY'S NEEDS BY NUMBERING THEM 1-9:		
___ Housing/Rent/Mortgage	___ Home/Auto Repair	___ Transportation
___ Clothing/Personal Items	___ Utilities	___ Groceries/Food
___ Tutoring	___ Scholarship	___ Photography

Section 4 – Required Supporting Documentation & Parent/Guardian Certification

I have attached written documentation from my treating physician and/or social worker on his/her letterhead stating the type of cancer diagnosed, the treatment prescribed and a statement that I am currently under treatment.

I understand that my application cannot be processed until I have completed all documentation and submitted it to the fax/address shown on top of this application.

- A completely filled out and signed application.
- A letter from the treating physician and/or social worker on his/her letterhead stating the type of cancer diagnosed, the treatment prescribed and a statement that I am currently under treatment.
- A letter from the applicant explaining their situation, need, etc.
- Supply the most recent pay stub and a copy of the previous calendar years W-2 and tax filing.
- Applicant must also include supporting documentation (copy of utility bills, mortgage coupon, etc) to support the items checked in the prioritized above.

Applicant must include a clear original photo (no photo copies) of the child that is diagnosed with cancer. If the patient is a parent then a photo of the parent(s) with the child(ren) is required. Applicant must sign the release, which gives the foundation your permission to publish on our website/newsletter a picture, a brief case history and grant summary.

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature and that any intentional misrepresentation of the information contained in this application will result in the loss of current and future assistance from Angels of Hope and may result in civil and or criminal liability. The Applicant hereby releases Angels of Hope from any and all liability which may arise from the sharing of this information with third-parties.

I also give Angels of Hope permission to publish in print, electronic, or video format the likeness or image of myself, child, and family. I release all claims against the foundation with respect to copyright ownership and publication including any claim for compensation related to use of the materials.

Parent/Guardian Signature

Date

Relationship to patient