Application for Financial Assistance

Adam's Angels Ministry, P O Box 2573, Brenham, TX 77834-2573
Phone: 979.836.0955 Email: angels@AdamsAngelsMinistry.org

Adam's Angels Ministry

Serving families who face childhood cancer.

OUR MISSION:
The mission of our organization is to provide financial assistance to families that have a CHILD between the ages of 0-20 yrs. of age who have been diagnosed with cancer, presently or recently receiving chemo, or recently deceased.

GUIDELINES FOR FINANCIAL ASSISTANCE:
The Financial Assistance Program provided by Adam's Angels Ministry is made possible because of generous donors. Our program was designed to ease the financial burden of a recent cancer diagnosis and help the family focus on healing. Our program is available to assist with rent/mortgage, car payment, utilities, telephone, food, and fuel to and from treatment.

OUR NETWORK OF TEXAS COUNTIES:
Washington, Austin, Brazos, Burleson, Fayette, Grimes, Lee, and Waller

AREA TEXAS HOSPITALS WE SERVICE:
Children's Cancer Hospital of MD Anderson, Houston, Katy, The Woodlands, Texas
Texas Children's Hospital, Houston, Katy, The Woodlands, Texas
Dell Children's Medical Center of Central Texas, Austin, Texas
Children's Memorial Hermann Hospital, Houston, Texas
McLane's Children's Hospital, Temple, Texas

ELIGIBILITY GUIDELINES:

- The patient must be on active treatment or 5 yrs. or less post-treatment for pediatric cancer.
- The patient/family must reside in one of **OUR NETWORK OF TEXAS COUNTIES** above.
- The patient's cancer diagnosis must be on or before his/her 20th birthday and treated before his/her 21st birthday.
- The patient diagnosed with cancer must come from a family currently experiencing financial stress due to the child's cancer treatment preventing a parent from working, resulting in financial distress.
- Financial stress occurring before the child's diagnosis is not considered a part of the financial hardship.
- The patient's caregiver/parent/guardian must complete and sign this Financial Assistance Application
- Applications must be completed in their entirety. Partial applications will n**o**t be considered.
- A current copy of the bill requesting assistance must be attached. (not an old bill)
- Submitted bills MUST be in the name of the applicant and not a third party.
- All rental assistance/mortgage payment requests must be supported by a lease agreement or note payment voucher. Partial rent or mortgage payments will not be made.
- The patient MUST be residing most of their time at the home where assistance is requested.
- The preferred method of payment by AAM is by Credit Card which is the fastest.
- Payments made by AAM, made by check, will be **payable to the creditors only on your behalf. (Account nos., phone numbers and/or required codes must be provided on the application.)**
- **Cash payments ARE NOT considered a form of payment by AAM and will not be made.**

ADDITONAL INFORMATION:
If you have questions, please call Adam's Angels Ministry 979.836.0955 or email angels@AdamsAngelsMinistry.org.

The AAM Board of Directors reserves the right to waive any of the above stated requirements.

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- The Financial Assistance Program was established to lighten the burden of a cancer diagnosis.
- Please make sure the application is complete and contains all additional documents. An incomplete application will delay assistance.
- Prioritize your needs for assistance.
- Applications will be reviewed, assistance determined by availability of funds, and as approved by our Board.

Section 1- Patient Information

Name (First, Middle, Last)			Diagnosis		Date of Diagnosis:
Date of Birth	Age	Gender	Patient disabilities: ☐No ☐Yes If yes, list below.		Signed up with Candlelighters? ☐Yes ☐ No Consultants Name:
Home Address (Street or PO Box, City, State, Zip)				Hospital Treated At:	
Social Worker Name & Phone #:	Oncologist Name:		☐ In Treatment ☐ In Maintenance ☐ Relapsed Projected Completion Date:		

Section 2 – Parent/Guardian Information

MOTHER/GUARDIAN INFORMATION			
Mother's/Guardian's Name	Primary Phone:	Home Cell	Number of People in Household Adults:
	Alternate Phone:	Home Cell	Kids:
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 the patient or family receive assistance from other agencies and or foundation(s)? If so, provide the amount received **per month** from the below agencies/foundation(s).

Alimony $_____ Child Support $_____ Disability $_____ Food Stamps $ _____
Fundraisers $_____ Go Fund Me $_____ SSI $_____ Unemployment $_____
VA Assistance $ _____ Housing Allowance $_____

Other: $_____ Explain: _____
Organizations: $_____ Name: _____

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Section 3 – Miscellaneous Information

Marital Status of Parents:	Attending a Church: ☐Yes ☐ No Name:	Facebook Page: ☐Yes ☐No Page Name:
May we add your child's name to our church prayer list: ☐Yes ☐No	List Siblings: Name	Gender Age
Patient's favorite color, hobbies or likes:		

Section 4 – Assistance Information

PLEASE CIRCLE AREAS REQUESTING ASSISTANCE WITH, THEN PRIORITIZE THE NEEDS/BILLS BY NUMBERING THEM.		
Housing/Rent/Mortgage $ _____ per month	Auto Repair	Fuel
Clothing/Personal Items	Utilities $ _____ per month	Groceries/Food
Telephone $ _____ per month		

Section 5 – Required Supporting Documentation & Parent/Guardian Certification

- I understand that my application cannot be processed until I have completed all documentation and submitted it to the email/address shown on top of this application or delivered it in person to AAM.
  - ❖ This application is completed in its entirety, signed and dated.
  - ❖ All supporting documentation (copy of utility bills, mortgage coupon, etc.) to support the items circled in the prioritized list above.
  - ❖ Applicant is encouraged to include a clear original photo (no photocopies) of the child diagnosed with cancer. Your child's identity will not be given in the photos.
- I certify that the information provided is true and correct as of the date set forth opposite my signature. The applicant releases the organization from all liability which may arise from the sharing of this information with third parties.
- I also give the organization permission to publish in print, electronic, and video format the likeness or image of myself, child, and family. I release all claims against the organization (Adam's Angels Ministry) with respect to copyright ownership and publication including any claim for compensation related to use of the materials.
- I authorize the verifier (social worker, healthcare provider, etc.) provided on this form to release information should it be needed (including diagnosis, treatment status and other pertinent information related to this Financial Assistance Application) to AAM as necessary to determine the processing of this Financial Assistance Application.

_____ _____ _____
Signature Parent/Guardian Signature Parent/Guardian Date

For AAM Use Only

Approved By: *Date:*

_____ _____

Board Liaison: _____

Anti-Discrimination Policy: You and your child will not be discriminated against or denied assistance because of your race, religion, color, national origin, gender, or political affiliation. All Financial Assistance Applications will be reviewed on a case-by-case basis and final determination will be made based upon your eligibility,