LIVING JOURNEYS

Living Journeys Financial Assistance Application

Living Journeys provides financial assistance, emotional support, and enrichment to Gunnison County residents living with cancer.

Application Instructions and Process:

- **First time applicants use this form**. If you have applied for assistance within the last 12 months, please find an abbreviated application called *Subsequent Application for Financial Assistance* at http://www.livingjourneys.org/applications

- Applications are reviewed on a quarterly schedule.

- Due to the limited budget of our non-profit, there is a $5,000 maximum request limit per quarter/per applicant for financial applications.

- This form can be completed on your computer and emailed to info@livingjourneys.org or printed and mailed to:
  PO Box 2024, Crested Butte, CO 81224

- **In order to complete this application, you will need to include the following:**
  - A copy of your photo ID
  - Your most recent 1040 tax form, if new since last application
  - The Medical Verification Form (see last page) must be submitted by a health care professional

APPLICATIONS MUST BE COMPLETE FOR CONSIDERATION.

Please contact Living Journeys at 970-349-2777 with any questions and we can help you complete the application.

THIS FORM SHOULD BE COMPLETED BY GRANT APPLICANT OR PARENT/GUARDIAN IF APPLICANT IS UNDER 18.

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PERSONAL INFORMATION		
Applicant Name:		Financial Grant Request: $
Applicant Date of Birth:		
Mailing Address:		
City:	State:	County:
Cell Phone:	Home Phone:	
Email:		
What is the best way to reach you?		
Emergency Contact Name:		
Phone:	Relationship to you:	
Second Emergency Contact Name:		
Phone:	Relationship to you:	
Do you have a support system?		
Are you in contact with an Oncology Nurse Navigator? If not, would you like to be put in contact with the ONN at Gunnison Valley Hospital for additional support?		

Please list all the members of your household below

Name	Relationship	Age	Does this household member have income? If yes, what kind? (employed, retired, disability, etc)

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FINANCIAL INFORMATION		
MONTHLY INCOME	GROSS	START DATE
Employment income	$	
Sick leave, workers' compensation, or disability insurance income	$	
SSI	$	
SSDI	$	
VA Benefits	$	
Retirement, pension, 401-K or IRA	$	
Child Support	$	
Spousal Support	$	
Public assistance	$	
Food stamps	$	
Employment income	$	
Any other income (unemployment or other ongoing income)	$	
TOTAL GROSS MONTHLY INCOME	$	
MONTHLY EXPENSES	AMOUNT	TOTAL BALANCE
☐ Rent ☐ Mortgage ☐ Own home outright Payment is made to:	$	
HOA fees	$	
Property taxes (if not included with mortgage)	$	
Home/renters insurance (if not included w/ mortgage	$	
Utilities (electric, gas, water, trash service)	$	
Telephone (land/cell), TV, Internet	$	
Monthly food expense: $200/m x # in household=	$	
Car payment(s)	$	
Car insurance	$	
Gasoline and oil	$	
Transportation (bus pass, cab fare etc.)	$	
Health insurance premium(s)	$	
Medical costs after insurance	$	
Prescription costs after insurance	$	
Life Insurance premium(s)	$	
Child care/child support	$	
Pet care	$	
Tuition	$	
Credit card payments	$	
Taxes and other payroll deductions	$	
Other non-medical bills, payments, or loans	$	
TOTAL MONTHLY EXPENSES	$	

FINANCIAL INFORMATION (continued)	
What are your total *cash* assets? *This includes checking and saving accounts.* $	What are your total *non-cash* assets? *This includes home equity, retirement savings, business assets, etc.* $
Do you have dependents to support? If yes, how many?	
Do you have health insurance? If so, please list.	Deductible: $ Out of Pocket Max: $
If your monthly income is less than your expenses, please explain how you are meeting your needs:	
Do you have unpaid medical bills that you cannot pay? Is yes, how much?	
Are you at risk of losing your home or any other major asset? If yes, please explain.	
Have you applied to other agencies for assistance? Is yes, please list.	

SUMMARY EXPLANATION
How is cancer currently affecting your life? *Please use this space to clarify how your life is currently being impacted by your cancer diagnosis. This can include more information about your treatment, your current financial situation, or anything else you think our Grants Committee should be aware of while reviewing your application.*
Please explain how you will utilize your requested financial assistance grant. Please be specific and list in order of priority:

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Please complete this checklist before you sign and submit this application:

- ☐ I have answered all the questions in this application to the best of my ability.
- ☐ I have included my Medical Verification Information Form or sent it to my health care professional with instructions (see last page).
- ☐ I have included my most recent 1040 Tax Form.
- ☐ I have included a copy of a photo ID

I certify that the information provided in this application is true and accurate to the best of my knowledge. I authorize Living Journeys to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my case that might be helpful for assessing my application. *I release Living Journeys of all liabilities or claims arising out of the donation of money or services provided to me or my family.*

Applicant Signature: *Your typed name serves as your signature*	Date:

☐ By checking this box, I allow Living Journeys to use my story (minus identifying characteristics) to solicit donations/funding to further help others undergoing cancer treatment.

Additional help is available through Living Journeys' other programs. Please check the boxes of services/notifications you are interested in:

- ☐ Applying for a Private Therapy grant
- ☐ Receiving support group email reminder and notifications
- ☐ Receiving assistance with transportation to treatment
- ☐ Receiving Youth Group emails and notifications
- ☐ Sign up for our client emails to learn about other services we provide

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MEDICAL VERIFICATION FORM

THIS PAGE MUST BE COMPLETED BY A REFERRING HEALTH CARE PROFESSIONAL (PHYSICIAN, NURSE, PATIENT NAVIGATOR, CASE WORKER OR SOCIAL WORKER). Please do not use abbreviations or codes for diagnosis and treatment. Do not send medical records. Please answer each question completely.

PATIENT INFORMATION		
Patient's Full Name:		
Cancer Diagnosis:	Diagnosis Date:	
Stage (please note if N/A):	Check if in remission ☐	
Name of Diagnosing Doctor:		
TREATMENT		
Describe current treatment plan:		
Surgery type:	Surgery Date:	Surgeon:
Hormone Therapy:	Begin Date:	Anticipated End Date:
Chemotherapy:	Begin Date:	Anticipated End Date:
REFERRING PHYSICIAN INFORMATION		
Name of referring professional (completing this form):		
Facility Name:		
Address:		
City:	State:	
Phone:	Email:	
Do you have any reservations concerning this patient's request for financial assistance?	☐ YES	☐ NO
Date you last saw this patient:		
Please describe the patient's health status when you last saw them:		
My signature below affirms the diagnosis and treatment information as described on this page.		
Signature: (Your typed name serves as your signature)	Date:	

FORM MUST BE COMPLETE FOR CONSIDERATION. CONTACT LIVING JOURNEYS IF YOU HAVE ANY QUESTIONS.

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