Subsequent Application for Living Journeys Financial Assistance

Living Journeys provides financial assistance, emotional support, and enrichment to Gunnison County residents living with cancer. Applications are reviews on a quarterly schedule.

Application Instructions and Process:

- If you have completed the Initial Application for financial assistance within the 12 months, then this is the form for you! **First time applicants must submit a different form**. Please find the *Initial Subsequent Application for Financial Assistance* at http://www.livingjourneys.org/applications

- You may request your previous application to help with the completion of this form – just call or email Living Journeys at 970-349-2777 or info@livingjourneys.org.

- 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:**
  - 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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<table>
<tr><th colspan="3">SUBSEQUENT FINANCIAL GRANT APPLICATION</th></tr>
<tr><td colspan="2">Name:</td><td>Grant Request: $</td></tr>
<tr><td colspan="3">List any changes regarding the Personal Information section of your previous application (this includes health insurance, current dependents, and contact info):</td></tr>
<tr><td>Current Monthly Income:
$</td><td colspan="2">Please explain any changes from your previous application:</td></tr>
<tr><td>Current Monthly Expenses:
$</td><td colspan="2">Please explain any changes from your previous application:</td></tr>
<tr><td colspan="3">If your income is less than your expenses, please explain how you are meeting your needs:</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><td colspan="3">Please explain how you will utilize your requested financial assistance grant. Please be specific and list in order of priority:</td></tr>
</table>

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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, if new since last application.

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

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.

970-349-2777 | info@livingjourneys.org