CHRISTMAS WITHOUT CANCER ASSISTANCE APPLICATION

Assistance *may* be provided based on individual needs determined after review from a Christmas Without Cancer representative. Please note: Help will only be considered if **ALL** criteria is met and **ALL** required documentation is submitted. Failure to comply can cause your application to not be processed. We are a local nonprofit that runs strictly on donations, which means our budget changes from month to month. With that said, Christmas Without Cancer *may* be able to assist a patient more than once during twelve (12) consecutive months OR until financial cap is met. Each financial cap is determined by committee and/or board members which *may* differ per applicant. If additional assistance is requested after twelve (12) consecutive months, a new application will be required.

PLEASE ANTICIPATE UP TO 2-4 WEEKS FOR THE APPLICATION PROCESS

Eligibility Requirements:

1. Patient must reside in Illinois and be seeking treatment in Illinois (within a 30-mile radius of Oak Lawn, Illinois 60453). ☐
2. Assistance must be for **CURRENT** cancer treatment. Active treatment is defined as in surgery and follow-up surgery, radiation, and/or chemotherapy. Assistance will not be retroactive for completed cancer treatment. ☐
3. Healthcare provider (physician, nurse, social worker, etc.) must sign the patient's application form and **MUST** include a letter on facility letterhead affirming that the patient is **CURRENTLY** receiving cancer treatment. ☐
4. Application **MUST** include a photocopy of your valid Illinois Driver's License or State I.D. A guardian submitting an application on behalf of a child, must submit a photocopy of their valid Illinois Driver's License or State I.D. ☐
5. Application form must be completed in full and submitted via mail, email or Fax. ☐
6. Assistance will not be received without the direct knowledge of the patient. ☐

X_____ PLEASE CHECK EACH BOX ABOVE AND INITIAL HERE ACKNOWLEDGING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE REQUIREMENTS

Please return completed application to:
Christmas Without Cancer
P.O. Box 628
Oak Lawn, IL 60454-0628
Fax: 708-658-1536
Email: christmaswithoutcancer@gmail.com

Website: www.christmaswithoutcancer.org
Facebook: https://www.facebook.com/ChristmasWithoutCancer/ | Instagram: christmas_without_cancer_nfp

Christmas Without Cancer

ALL INFORMATION IS REQUIRED IN ORDER TO PROCESS APPLICATION
PLEASE PRINT CLEARLY USING BLACK OR BLUE INK

PERSONAL INFORMATION:

Application date: ____ /____/____ Name of Patient: _____

Name of Legal Guardian (if submitting on behalf of a minor): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home: (____) _____ Cell: (____) _____ Work (____) _____

Email Address: _____ Date of Birth: ____ /____/____

Driver's License/State I.D. # _____ Last 4 digits of SSN _____

Gender: Male ____ Female _____

Marital Status: Single ___ | Partnered/Married ___ | Widowed ___ | Divorced ___

Children/Dependents in the home: Yes / No – If yes, names/ages: _____

_____

Race/Ethnicity: White/Caucasian ___ African American ____ Hispanic/Latino ____
Native American/American Indian ____ Asian American/Pacific Islander ____

MEDICAL INFORMATION:

Diagnosis: _____

Date of Diagnosis: ____ /____/____ Date of Relapse: ____ /____/____

Hospital/Facility of Treatment: _____

Name of Physician/Nurse Practitioner: _____

Name of Social Worker: _____ Other (specify): _____

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HEALTH INSURANCE INFORMATION:

- Do you have health insurance? Yes / No
- Do you pay for your health insurance monthly? Yes / No
  - If yes, amount $_____
- Please indicate types of insurance (check all that apply)
  - Medicaid ____ Medicare only _____ Private insurance ____ Cobra ____ Medicaid +Medicare ____ Charity Care ____ Medicare +Supplemental Insurance ____
  - Other _____
- If not covered, have you applied for Medicaid? Yes / No

ADDITIONAL INFORMATION:

- How did you find out about Christmas Without Cancer? _____

  ***If an individual referred you, please list their first and last name.**
- Are you receiving additional assistance from other local nonprofits or agencies? Yes / No
  - If yes, please let us know how they have assisted you or your family: _____

    _____
- Our organization may provide VISA gift cards for groceries, medication and/or gas expenses. These can be used anywhere VISA debit cards are accepted within the US.
  - Other gift card requests (be specific): _____
- Do you have a bank account? Yes / No
  - If not, please let us know what facility you will use to cash a check? Some facilities may call our organization for confirmation. _____

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- Do you have your own transportation to/from treatment, etc.? Yes / No
  - If not, please let us know what transportation service you use (Pace, Family/Friends, Uber, Lyft, etc.). _____
- Are you currently past due on any household bills (mortgage, rent, car, tuition, utilities, etc.)? If so, please let us know (please note proof may be requested): _____

  _____

  _____
- Additional information regarding patient: _____

  _____

  _____

  _____

  _____

APPROVALS:

- Patient Signature or Legal Guardian Signature: _____
- Healthcare Provider Signature: _____

BEFORE SUBMITTING, PLEASE CONFIRM:

◯ Application is signed by patient or legal guardian

◯ Application is signed by healthcare provider (physician, nurse, social worker, etc.)

◯ Letter on facility letterhead confirming that the patient is **CURRENTLY** receiving cancer treatment

◯ Photocopy of your valid Illinois Driver's License or State I.D. is attached

!!Failure to provide any of the above will cause your application to be automatically rejected!!

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Christmas Without Cancer

PHOTOGRAPHY/FACEBOOK AUTHORIZATION RELEASE FORM

I hereby grant to Christmas Without Cancer NFP the irrevocable and unrestricted right to use and publish photographs of me, or in which I may be included, for library publications, electronic reproductions (websites) and/or promotional materials or any other purpose and in any manner or medium. In addition, I grant my permission to alter the same without restrictions; and to copyright the same. I hereby release the photographer and Christmas Without Cancer NFP from all claims and liability relating to said photographs.

Printed Name: _____ Date: ____ / ____ / ____

Signature: _____ Phone: (___) _____

Address: _____

City: _____ State: _____ Zip Code: _____

If person is under the age of 18:

I, _____ am the parent/guardian of the individual named above.

Printed Name: _____ Date: ____ / ____ / _____

Signature: _____ Phone: (___) _____

Address: _____

City: _____ State: _____ Zip Code: _____

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