Christmas Without Cancer

CHRISTMAS WITHOUT CANCER ASSISTANCE APPLICATION

Support *may* be granted on a one-time basis, contingent upon the specific needs assessed by a representative of Christmas Without Cancer. Applicants will be evaluated only if all criteria are satisfied and all necessary documentation is provided. Noncompliance will result in an automatic rejection of the application. As a local nonprofit organization that relies entirely on donations, our budget varies each month. Consequently, we cannot guarantee assistance.

PLEASE EXPECT AT LEAST 2-4 WEEKS FOR YOUR APPLICATION TO BE PROCESSED

Eligibility Requirements:

- ☐ Patient must reside in Illinois within a 30-mile radius of Oak Lawn (60453), and the patient must be seeking treatment in Illinois within a 30-mile radius of Oak Lawn (60453).
- ☐ Patient must be in **ACTIVE** cancer treatment. Active treatment is defined as "in surgery and follow-up surgery, radiation, and/or chemotherapy." Individuals who have completed, declined, or discontinued treatment are not eligible for assistance from Christmas Without Cancer.
- ☐ Healthcare provider (physician, nurse, social worker, etc.) must sign the patient's application form and **MUST** include a letter on facility letterhead confirming that the patient is in **ACTIVE** cancer treatment.
- ☐ Application **MUST** include a **CLEAR** photocopy of your valid Illinois Driver's License or State I.D. A guardian applying on behalf of a child or ward must submit a photocopy of their own valid Illinois Driver's License or State I.D. A Guardian applying on behalf of a ward must submit a copy of the Letters of Guardianship.
- ☐ Application form must be completed in full and submitted via mail, email, or fax.
- ☐ Assistance will not be received without the patient's direct knowledge except in circumstances where the patient is a minor child or an incapacitated adult.

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

ALL INFORMATION IS REQUIRED TO PROCESS APPLICATION

!!INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED!!

Please return the completed application to:
Email: christmaswithoutcancer@gmail.com
Fax: 708-658-1536
Mail: P.O. Box 628 Oak Lawn, IL 60454-0628

Learn more: www.christmaswithoutcancer.org
Follow us on social media: Facebook – Christmas Without Cancer | Instagram – christmas_without_cancer_nfp

TO BE COMPLETED BY CWC REPRESENTATIVE:
APPLICATION #: _____
APPROVED | REJECTED: _____
DATE: _____/_____/_____

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PERSONAL INFORMATION:

Application Date: ___ / ___ / ___

Name of Patient: _____

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

Address: _____

City: _____ State: _____ Zip Code: _____

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

Driver's License / State I.D. #: _____ SSN: _____- ___ - _____

Sex* Female US Citizen* No Military Veteran* No

Marital Status* Single ◯ Married (Partnered) ◯ Widowed ◯ Divorced ◯ Separated ◯

Race / Ethnicity* White / Caucasian ◯ African American ◯ Hispanic / Latino ◯
Native American / American Indian ◯ Asian American / Pacific Islander ◯

Fields denoted with an asterisk (*) are for statistical purposes only and do not affect assistance decisions.

Number of Household Members: _____

Names and Ages of all Household Members (including Patient):

_____

_____

_____

_____

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? No

If not covered, have you applied for Medicaid? No

Do you pay for your health insurance monthly? No

If yes, amount: $ _____

Please indicate types of insurance (check all that apply)

Medicaid ☐ Medicare only ☐ Private Insurance ☐ COBRA/IL Continuing ☐

Charity Care ☐ Medicaid + Medicare ☐ Medicaid + Supplemental Insurance ☐

Other (please specify): _____

FINANCIAL INFORMATION:

Current Employment Status? Employed ◯ Unemployed ◯ Retired ◯ Disabled ◯

If unemployed, what was our last date worked? ___ / ___ / ___

Are you receiving unemployment benefits? No

If disabled, are you receiving disability? No

If yes, what type of disability (i.e. short-term, long-term, social security, private policy, etc.): _____

_____

Monthly amount: $_____

Are you or other household members required to file a federal tax return? No

Are you claimed as a dependent on any federal tax return? No

How many people live in your household and are claimed as dependents on your tax return?
(Example: You, your spouse, and two children = 4) _____

What was your household gross income in the last calendar year? $_____

IF REQUESTING A FINANCIAL GRANT EXCEEDING $500
We require the following financial documents

Please submit the following information relating to income verification for your household:

- Two most recent paystubs and/or social security and pension statements
- Copies of your last two federal tax returns
- Bank statements (previous two months)

(Please note that additional documentation may be requested)

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ADDITIONAL INFORMATION:

How did you hear about Christmas Without Cancer? _____

*If an individual referred you, please list their first and last name.

Are you receiving assistance from other nonprofits or agencies? Yes / No

If yes, please let us know who and 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. _____

Do you have 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 past due on any household bills (mortgage, rent, car, tuition, utilities, etc.?) Yes / No

If yes, please let us know (proof may be requested): _____

_____

_____

Additional patient information: _____

_____

_____

APPROVALS:

Patient Signature or Legal Guardian Signature: _____

Healthcare Provider Signature: _____

BEFORE SUBMITTING, PLEASE CONFIRM:

- The patient or legal guardian signs the application
- Application is signed by a healthcare provider (physician, nurse, social worker, etc.)
- A letter on facility letterhead confirming that the patient is CURRENTLY receiving cancer treatment is attached
- A clear photocopy of your valid Illinois Driver's License or State I.D. is attached
- Required income verification documents are attached if requesting a financial grant exceeding $500

!!FAILURE TO PROVIDE ANY OF THE ABOVE WILL CAUSE YOUR APPLICATION TO BE AUTOMATICALLY REJECTED!!

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APPLICANT DECLARATION AND RELEASE FORM

I verify that the information provided in my application is complete, accurate, and true. I further understand that reported financial information may be verified by an audit as deemed necessary by Christmas Without Cancer NFP. I understand that if I am approved for assistance by Christmas Without Cancer NFP, assistance will be revoked if any fraudulent activity related to the application is identified. I further understand that if assistance is revoked due to fraud, I may be required to reimburse Christmas Without Cancer for any assistance already received

I understand that any assistance Christmas Without Cancer NFP may provide is at the sole discretion of Christmas Without Cancer NFP and that Christmas Without Cancer NFP reserves the right at any time and for any reason, without notice, to refuse or discontinue assistance.

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 the 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: _____

WAIVER AND RELEASE OF LIABILITY

In consideration for being potentially considered to participate in programs, events, and/or activities sponsored by Christmas Without Cancer NFP, I, for myself, my executor, administrators, heirs, and anyone entitled to act on my behalf, hereby waive, discharge, and covenant not to sue Christmas Without Cancer NFP, its management, officers, board members, employees, members, sponsors, licensees, volunteers, their successors, and all cooperating businesses and organizations, the event site, organizers, or their representatives, for any and all liability, claims, demands, damages, causes of action, losses, or expenses arising out of my participation in the event and any related activities.

I understand that I may be photographed, filmed, or videotaped in connection with my involvement with Christmas Without Cancer NFP. I hereby irrevocably grant to Christmas Without Cancer NFP, its affiliates, licensees, and collaborators the absolute right and permission to distribute, publish, exhibit, digitize, broadcast, display, reproduce, photograph, videotape, and otherwise use my name, picture, portrait, likeness, writings or biographical information (including, if applicable, information regarding my disease diagnosis, prognosis, and treatment), and audiotape and/or videotape recordings and sound or silent motion pictures of me in any manner or media whatsoever anywhere in the world in perpetuity for any lawful purpose whatsoever, including without limitation, for editorial, educational, promotional, and advertising purposes, for the solicitation of contributions, as evidence in litigation, and for any other purposes in furtherance of the purposes and objectives of Christmas Without Cancer NFP.

I hereby release, discharge, and agree to hold harmless Christmas Without Cancer NFP and its employees, agents, affiliates, legal representatives or assigns, and all persons acting under its permission or upon its authority, from any liability by virtue of any publication of my likeness, including, without limitation, claims for libel or invasion of privacy. I further agree that Christmas Without Cancer NFP shall be the exclusive owner of all copyright and other rights in such media.

I have carefully read this Waiver and Release of Liability and fully understand its contents. I am at least 18 years of age and I am competent to contract in my own name. I am aware that this is a release of liability and a binding contract between myself and the persons and entities mentioned above and I sign it of my own free will. I understand that I am giving up substantial rights, including my right to sue. I acknowledge that I am signing this Waiver and Release of Liability freely and voluntarily, and intend by my signature to be a complete and unconditional release of all liability to the greatest extent allowed by law.

Printed Name: _____

Signature: _____ Date: ___ / ___ / ___