BLUE WATER LITTLE BLACK DRESS
Betty Kearns Cancer Fund

Financial Support Request CONFIDENTIAL

Today's Date: _____

SECTIONS I, II AND III PREFERABLY COMPLETED BY NURSE, SOCIAL WORKER, PATIENT NAVIGATOR OR OTHER MEDICAL PROFESSSIONAL

I. CLIENT INFORMATION

Name_____ Date of Birth_____

Address_____ Phone_____

City_____, Michigan Zip Code_____

County_____ Email Address_____

II. MEDICAL INFORMATION

Was client diagnosed within the last 12 months? Yes ☐ No ☐ Date of Diagnosis: _____

Primary Cancer: _____ Stage: _____

Is client in active treatment? Yes☐ No☐ Date treatment began: _____

☐Chemotherapy☐Radiation☐ Surgery☐Hormonal ☐Reconstruction☐Lymphedema

Has client completed treatment? ☐ Yes ☐ No Date treatment ended: _____

Additional information: _____

_____

_____

_____

III. REFERRAL INFORMATION (nurse, social worker, patient navigator)

Name: _____ Title: _____

Institution: _____

Email: _____ Phone: _____

Client has signed HIPAA Privacy Authorization Form granting permission to share the aforementioned medical information with Betty Kearns Cancer Fund for the purposes of this application.

Signature: _____ Date: _____

IV. HOUSEHOLD FINANCIAL INFORMATION

Employment status at time of diagnosis: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disability
Employment status at time of application: ☐ Full-time ☐ Part-time ☐ Retired ☐ Unemployed ☐ Disability

Name of last Employer: _____
Address: _____
Email: _____ Phone: _____
Average Weekly Income: _____
Last day of Employment: _____

Number of Adults living in household _____ (not including adult children in college or legal dependents)
Number of dependents living in household _____ (minors under 18 or adult children 18-26 still in school/college)

Information must be provided for all adult/non-dependents living in household. Please include all sources of income, including payroll/unemployment benefits, SSD/SSI, public assistance, alimony/child support. Adult children attending college do not have to be listed here; however, all other household adults, including roommates, should be listed.

☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ $_____/monthly
Source Amount

☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ $_____/monthly
Source Amount

☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ $_____/monthly
Source Amount

☐ Self ☐ Spouse/Partner ☐ Adult Child ☐ Other _____ $_____/monthly
Source Amount

Total Monthly Family Income: $_____Total Monthly Household Expenses: $_____
Housing Status: ☐ Mortgage-Current ☐ Mortgage-Delinquent ☐ Renting ☐ Living with others ☐ Other_____

Financial Assets: Checking Account/Money Market: $_____ Savings Account: $_____

Please detail how cancer has lead you to face financial hardship:

_____

_____

Have you applied for/received a BKCF Fund grant previously? ☐ Yes ☐ No When? _____

V. FINANCIAL SUPPORT DETAIL

Betty Kearns Cancer Fund provides temporary financial assistance to men, women & children who are experiencing financial distress due to cancer. Expenses incurred prior to cancer diagnosis are not eligible for assistance. Grants typically cover mortgage/rent, utilities, transportation costs including car insurance, COBRA or health insurance premiums, medical expenses such as co-pays, prescription costs, deductibles and medical bills including bills for doctor visits, diagnostic testing, treatment and other expensed incurred by cancer diagnosis. Credit card bills and student loans are not eligible. Funding is limited and based on availability and eligibility.
On the next page, please provide detailed information for all bills submitted. All fields must be completed. Supporting documentation must be included with your application, which can include:

- A copy of most recent bill/statement/invoice.
- A copy of payment coupon for installment loans such as mortgage or car payment
- A copy of the rental agreement if you do not receive a monthly statement from your landlord.

- A copy of legal order with payment terms and instructions

Please make sure that you provide a copy of the most recent statement, bill or invoice. Account screen shots from your computer are not eligible unless they show account number, amount owed, billing address and your name/address.
We cannot process payments without payee information including an account number and mailing address.

BILL STATEMENT SUMMARY

Please list bills in order of priority; when funds are limited, we will consider bills in the order they are listed below.

Assistance requests cannot be processed without **ALL** of the information below as well as a corresponding bill statement for each request. Payments are sent from Betty Kearns Cancer Fund directly to the creditor, not to the client.

Type of Bill: _____Account #_____

Amount: _____ Payable To: _____

Address: _____City: _____State: ___ Zip Code _____

Type of Bill: _____Account #_____

Amount: _____ Payable To: _____

Address: _____City: _____State: ___ Zip Code _____

Type of Bill: _____Account #_____

Amount: _____ Payable To: _____

Address: _____City: _____State: ___ Zip Code _____

Type of Bill: _____Account #_____

Amount: _____ Payable To: _____

Address: _____City: _____State: ___ Zip Code _____

Type of Bill: _____Account #_____

Amount: _____ Payable To: _____

Address: _____City: _____State: ___ Zip Code _____

Please attach an additional page if you have more information to provide.

Incomplete applications will not be accepted. Acceptance of your application does not guarantee approval of all bills submitted. The BKCF Committee will review each request to determine eligibility and approval based on available funds. The applicant will be notified of your application status. Please be advised that it can take 4-6 weeks for payments to process from the date of your application. If your application is not accepted or not approved, the applicant will be notified. Your creditors will be paid directly. We do not pay financial grants directly to clients.