Help when cancer strikes

angel foundation

ONE APPLICATION

- Emergency Financial Assistance Grant
- Financial Cancer Care Program
- Adult & Family Programs

Application Requirements

- Patient completes **all sections** and signs the application.
- A member of your oncology care team completes and signs the Medical Information Form.

THREE WAYS TO COMPLETE APPLICATION

1. Complete printed copy and return in-person or via email to:
   Angel Foundation
   1155 Centre Pointe Dr., Ste. 7
   Mendota Heights, MN 55120
   or you can email it to
   grants@mnangel.org
2. To apply online, please visit **mnangel.org**
3. Scan this QR code

I am applying for:

☐ Emergency Financial Assistance (EFA) Grant

EFA supports adult cancer patients by relieving some of their non-medical living expenses. To be eligible, the patient must:

- Be 18 years of age or older.
- Be in active treatment** for cancer.
- Meet financial guidelines set by Angel Foundation™.
- Be a Minnesota or Wisconsin resident living or receiving cancer treatment in the following fifteen Minnesota or Wisconsin Counties: Anoka, Carver, Chisago, Dakota, Douglas (WI), Hennepin, Isanti, Olmsted, Ramsey, Scott, Sherburne, St. Croix (WI), St. Louis, Washington, and Wright.

**Treatment includes one or more of the following:

- Chemotherapy
- Clinical trials
- Hormone therapy
- Hospice
- Immunotherapy
- Palliative care
- Radiation
- Transplant
- Surgery
- Other treatment per healthcare provider

☐ Financial Cancer Care (FCC) Program

Designed to help patients impacted by cancer manage finances through virtual workshops and one-on-one planning with a Certified Financial Planner© (CFP©).

For patient or family member to register for the FCC Workshop:

- 18 years of age or older.
- Live in or receive cancer treatment in one of the fourteen counties listed above.
- Have received treatment** for cancer within the last two years.

To meet one-on-one with a CFP©:

- Meet all FCC Workshop criteria.
- Be financially independent.
- Not currently be working with a Financial Planner.

☐ Adult & Family Programs (AFP)

Provide education and social activities designed to help families and individuals emotionally and practically after a loved one is diagnosed with cancer.

All families impacted by cancer in our service area can participate.

☐ Angel Packs™

Are designed to support children when a loved one is diagnosed with cancer, Angel Packs™ include engaging activities, coping tools, and a parent guidebook to facilitate age-appropriate conversations. Each pack helps families navigate the challenges of cancer while providing reassurance and valuable support strategies.

- **Circle your desired pack type(s):** Child: 4-8, Preteen: 9-12, Teen: 13-18.

Patient Information *Required

Who is filling out the application?*

- ☐ I am the patient, applying for myself.
- ☐ I am an oncology healthcare professional assisting the patient.
- ☐ I am assisting the patient and will indicate my relationship below.

Your name: _____ Relationship to patient: _____

First Name*_____ Middle Initial _____ Last Name* _____

Preferred Name _____Birthdate* (MM/DD/YYYY) ____/_____/_____

Street Address*_____ Apt # _____

City* _____ State* _____ Zip* _____ County* _____

Phone/Mobile* _____ Email* _____

Please list others we can discuss your application with besides your oncology team:

_____

_____

Would you like Angel Foundation™ to contact you regarding other community resources?

- ☐ Yes
- ☐ No

If yes, how would you like to be contacted?

_____

How would you like to be contacted about your application?*

- ☐ Email
- ☐ Letter

May we leave a message on your phone?*

- ☐ Yes
- ☐ No

Do you need language translation?

- ☐ Yes
- ☐ No

If yes, what language? _____

_____

Demographic Information

Your responses to the following questions enable Angel Foundation™ to better serve communities equitably. All responses are kept private and secured and will not be used for discriminatory purposes.

What gender do you identify as?*

- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Two-Spirit
- ☐ Prefer not to answer
- ☐ Other (Please Specify)

Have you participated in active duty in the military?*

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

What race, ethnicity, or tribal affiliation do you identify with?*

- ☐ American Indian or Native Alaskan
- ☐ Asian, Native Hawaiian, or Pacific Islander
- ☐ Black or African American
- ☐ Hispanic, Latina/o/x Spanish origin
- ☐ Middle Eastern or North African
- ☐ Non-Hispanic White
- ☐ Two or More Races
- ☐ Prefer not to answer
- ☐ Tribal Affiliation (Please specify)

  _____
- ☐ Other (Please specify)

Marital Status*

- ☐ Divorced
- ☐ Married
- ☐ Partnership
- ☐ Separated
- ☐ Single
- ☐ Widowed
- ☐ Prefer not to answer

Medical Information

Cancer Diagnosis:* _____

Cancer Stage*

☐ I ☐ II ☐ III ☐ IV ☐ O ☐ None Specified ☐ Remission ☐ Recurrent

Type of Treatment:* _____

Clinic/Hospital Name:* _____

City:* _____

Oncologist Name:* _____

Household Information

Please list the total number of people living in your household, including yourself:* _____

Do you have school-aged children in your household (ages 4-18)?*

☐ Yes ☐ No

If yes, please list their names and ages:

Child 1 Age, Name:
Child 2 Age, Name:
Child 3 Age, Name:
Child 4 Age, Name:

If you have more than four children, check this box: ☐

What is your housing situation?*

☐ Stable ☐ Unstable ☐ Prefer not to answer

Medical Insurance Provider: _____

Total Net Monthly Household Income (after taxes):* _____

Additional Information

How did you hear about Angel Foundation™?*

- ☐ Community Health Worker
- ☐ Community Organization (please specify) _____
- ☐ Doctor
- ☐ Friend/Relative
- ☐ Internet
- ☐ Nurse
- ☐ Patient Counselor/Navigator
- ☐ Social Worker

May we add you to our mailing list?*

☐ Yes ☐ No

Will you be willing to share your story with our community?*

☐ Yes ☐ No This is not required to receive assistance. If you choose yes, someone from Angel Foundation™ may contact you.

Please tell us anything else you would like us to know:

_____

_____

_____

_____

☐ Please check here to be contacted about your situation.

Patient Release

☐ I declare the information on this application is true and correct to the best of my knowledge. I understand that each application is reviewed on a case-by-case basis, and the final decision will be made by Angel Foundation™. I hereby give my permission that this application and all information offered can be provided to Angel Foundation™ and discussed with my healthcare professional. I understand that all information reviewed is confidential.

Signature*_____ Date of Signature* _____/_____/_____