MEDICAL VERIFICATION FORM: THIS PAGE MUST BE COMPLETED BY A REFERRING PROFESSIONAL
Answer each question completely. Print clearly and use dark ink.

Parent/Guardian name (if patient is under 18):	
Cancer diagnosis:	Stage (please note if N/A):
Describe current treatment *(begin & end dates are required)*:	Diagnosis Date:
☐ Surgery Type: Date of Surgery:	Name of physician:
☐ Chemotherapy Begin date: Anticipated end date:	
Chemotherapy Agent(s):	
☐ Radiation Begin date: Anticipated end date:	
☐ Hormone Begin date: Anticipated end date:	
Patient insurance status: ☐ None ☐ Medicare ☐ Medicaid ☐ CICP ☐ VA ☐ Private ☐ Other:	
Has the patient applied to T. Grace Foundation before? ☐ YES ☐ NO	
If yes, when?	
Is patient currently able to work? ☐ YES ☐ NO	If no, what date will patient return to work?
Patient financial needs: ☐Rent ☐Mortgage ☐Hotel/other housing ☐Utilities ☐Food ☐Transportation ☐Medical ☐Other	
****For the application to be eligible, we must have the following contact information****	
Name of referring professional (*health care professional completing form*):	
Facility: Address: City: State: ZIP:	
Phone: ( ) E-mail: ☐ ☐	
Do you have any reservations concerning this patient's request forfinancial assistance? YES NO	
Referring professional's summary regarding patient and their household's financial situation: **(This is required, please include as attachment as needed)**	
Must be signed by referring professional *(case worker, patient navigator, social worker, nurse, physician)*	
My signature below affirms the diagnosis and treatment information as described on this page.	
Signature:	Date:

PERSONAL DATA —TO BE COMPLETED BY GRANT APPLICANT *(or parent/guardian if patient is under 18)*
Answer each question completely. Print clearly and use dark ink.

Parent/Guardian name (if patient is under 18):			Patient Date of Birth:
Mailing Address:			Apt #:
City:	State:	ZIP:	County:
Phone: Home ( )		Cell ( )	
E-mail address:			
I am: ☐Single ☐Partnered ☐Domestic Partnership/Civil Union ☐Married ☐Separated ☐Divorced ☐Widowed			
How may we reach you if we have questions?			
Preferred language:			
If employed or disabled, who is/was your employer:			
How long have you/did you work for this employer?			
What kind of work do/did you do?			
After you have recovered, can you return to work for this employer?			

List the names of all people living in your home

Name	Relationship	Age	Employment (of adults over 18)				
			Full time	Part time	Disabled	Retired	Unemployed
Applicant Name	***Self***						

Comments (Explain unemployed or other situation)

INCOME & ASSETS — TO BE COMPLETED BY GRANT APPLICANT

Tell us about your total household income **this month**. Please report gross earnings (before taxes or other deductions). You'll be able to report the amount you pay in taxes and deductions on the next worksheet.

Attach copies of income for your entire household (paystubs, social security letters, pension statements, etc.)

Income this month	**Gross Monthly Amount** *(before taxes)*	**Start Date** *(date you began receiving this income)*	**End Date** *(date you Stopped receiving this income)*
1) Your gross monthly income from working	$		
2) Your spouse/partner's gross monthly income from working	$		
3) Other household members' gross monthly income	$		
4) Sick leave, workers' compensation, or disability insurance income	$		
5) SSI	$		
6) SSDI	$		
7) VA benefits	$		
8) Retirement, pension, 401-K or IRA	$		
9) Child support	$		
10) Spousal support	$		
11) Public assistance	$		
12) Food stamps	$		
13) Other income *(unemployment or other ongoing income)* Describe:	$		
Total Gross Monthly Income	$		

Assets	
1) Checking account balance: $	Bank Name:
2) Savings account balance: $	Bank Name:

Write yes or no. If yes, provide value, loan, and income.	**Value**	**Loan**	**Income**
3) Do you own or are you buying a home?	$	$	$
4) Do you own or are you buying a car?	$	$	$
5) Do you own or are you buying another car?	$	$	$
6) Do you own a business or any part of a business? *	$	$	$
7) Do you have any investments, stocks or bonds?	$	$	$
8) Do you have any rental properties?	$	$	$
9) Do you own any other real estate properties?	$	$	$
10) Do you own any annuities?	$	$	$
11) Do you own "cash value" life insurance?	$	$	$
12) Do you have any other assets?	$	$	$

***Note: If you answer "yes" to question #6, please provide a current balance sheet for your business.**

EXPENSES — TO BE COMPLETED BY GRANT APPLICANT

Please list **all** your household's expenses for **every single member** of your household **this month** so that we have an accurate picture of your financial situation.

Attach copies of your first and second top priority bills

Expenses This Month		
Expense	**Payment/Amount**	**Total Balance**
1) Rent or mortgage	$	
2) HOA fees	$	
3) Property taxes *(if not included with mortgage)*	$	
4) Home/renters *(if not included w/ mortgage)*	$	
5) Utilities (electric, gas, water, trash service)	$	
6) Telephone (land/cell), TV, internet	$	
7) Monthly food expense*: **$200/m x # in house =**	$	
8) Car payment(s)	$	
9) Car insurance	$	
10)Gasoline and oil	$	
11)Transportation *(bus pass, cab fare, or other)*	$	
12) Health insurance premium(s)	$	
13) Medical costs **after** insurance	$	
14) Prescription costs **after** insurance	$	
15) Life Insurance premium(s)	$	
16) Childcare/child support	$	
17) Pet care	$	
18) Other non-medical bills, payments, or loans*	$	
19) Credit card payments	$	
20) Taxes and other payroll deductions	$	
21) Tuition	$	
Total Monthly Expenses	$	

*Describe expenses from line ***18*** here (you can also use this space to clarify anything you'd like about your expenses):

GRANT REQUEST APPLICATION —TO BE COMPLETED BY GRANT APPLICANT

☐ Unrestricted Grant only ☐ Restricted Grant only ☐ Both

Have you applied to other agencies for assistance? ☐ Yes ☐ No If yes, please list the agency and their response to your request for assistance. If no, why not? ***(We encourage you to seek assistance from any & all agencies & resources. Assistance from other resources does not affect eligibility)***
Summarize your current financial situation **(this is required).** Include as attachment as needed.
I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize T. Grace Foundation 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 hereby consent to release of my medical information to T Grace Foundation. *I certify that I am either a U.S. Citizen or Legal Resident of the United States.* *I release T. Grace Foundation of all liabilities or claims arising out of the donation of money provided to me or my family.*

Applicant's Signature:	Date:

☐ By checking this box, I allow the T. Grace Foundation to use my story (minus identifying characteristics) to solicit donations/funding to further help others undergoing cancer treatment.

APPLICATION CHECK LIST:

- ☐ My name is on every page of this application.
- ☐ I am either a U.S. Citizen or Legal Resident of the United States.
- ☐ I have verified that my income does not exceed the guidelines listed on the application cover page, if I am applying for the guaranteed assistance subsidy.
- ☐ I have included all income and expense information for my **entire household**.
- ☐ I have totaled the amounts on the income and expense pages *(pages 3 and 4).*
- ☐ I have attached copies of household income (recent paystubs, social security letters, pension statements, etc.)
- ☐ I have attached copies of the most recent statements for my top 2 priority expenses (mortgage, utility, etc.). *(Do not include bills for medical expenses, life insurance, credit cards, or bills payable to family members.)*
- ☐ I have attached a copy of my photo I.D.
- ☐ A health care professional that is knowledgeable about my diagnosis and treatment has completed and signed the medical verification on page 1.
- ☐ I have signed this application.