MJ's Gift Financial Assistance Program

The MJ's Gift Financial Assistance Program is dedicated to supporting women on Cape Cod with gynecologic cancers by helping with medical and daily living expenses during and immediately after cancer treatment.

Grants may be given to qualified applicants in the amount of $750 per year for such things as:**

- Medical expenses
- Prescriptions
- Rent or mortgage payment
- Utility bills
- Car payment
- Car insurance
- Health insurance deductibles
- Psychiatrist visits

To Qualify for Assistance: (Submission of an application in not a guarantee of assistance)

Gynecologic cancer patients who meet the following residency, medical and financial qualifications may submit an application for consideration.

Residency: (Proof of Cape Cod residency is required with the application.)

Medical:

1. Diagnosis of a gynecologic cancer

2. Currently receiving treatment (e.g. chemotherapy, radiation therapy, surgery, PARP-inhibitor) or completed treatment for a gynecologic cancer within the last three months.

Financial:

1. Your monthly household expenses must be more than your monthly household income (defined as income received from patient and their domestic partner, regardless of gender), and your total household income must be less than or equal to 300% of the HHS Federal Poverty Level. In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your county. (www.huduser.org)

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2. Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.

You may be asked to provide additional paperwork in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, Sue's Gift has the right to withdraw your application, stop all assistance and take steps to recover previous awards.

Follow these steps below to apply for assistance.

Step 1: Fill out the Sue's Gift Application pages 1 – 4.

Step 2: Have your oncologist's office complete the Medical Verification form on page 5 which can be returned with your completed application or the office may send it in separately.

Step 3: Make a copy of your current Colorado Driver's License, Colorado-issued I.D. **or** other proof of residency with an address matching your application (e.g. utility bill, etc.), and include with your application.

Step 4: Mail your completed application** and all required attachments to:

Sherry Martin, LCSW
Sue's Gift
525 N. Cascade Ave., Suite 213
Colorado Springs CO 80903

**For quicker processing, email the application to sherry@suesgift.org or fax it to 719-264-1094. Please be sure to provide all the information requested here. An incomplete application will delay our ability to provide you with assistance.

Once we receive your application, the Sue's Gift Task Force committee will review it and send you an Agreement or Decline letter by mail or email. If your application has been accepted, you will be contacted to determine how to proceed with bill payment.

This is also a time to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact: Sherry Martin, Patient Services Director, at 719-422-9964 or sherry@suesgift.org.

SUE'S GIFT FINANCIAL ASSISTANCE PROGRAM

Personal Information

Last Name______________________ First Name_____________________ Middle Initial_______

Address___________________________ City_________________ State______ Zip__________

County____________Date of Birth __________ Email address____________________________

Phone: Home _________________ Mobile_________________ Work ________________

Best way to reach you: (circle one) Home Phone Cell Phone Work Phone Email

Best time to reach you: (circle one) Morning Afternoon Evening Best hours:__________

Marital Status: (circle one) Single Married Partnered Separated Divorced Widowed

Preferred Language: _____English _____Spanish

Additional Contact Person:

Name____________________________ Relationship_______________ Phone______________

Email_____________________________ Do you have health insurance? ____Yes ____No

(check all that apply) ____Private insurance ____Medicare ____Medicaid ____ VA ____ Other

If private insurance, please name insurance company ___________________________________

Comments: ____

Are you currently working? ____Yes ____No If yes, how many hours per week? _________

Were you working before your cancer diagnosis? ____Yes ____No

Total # in household_________ # of wage-earners in home_________ # of dependents________

Who referred you?__________________________ Referring person's phone________________

Referring person's email____

Have you received Sue's Gift before? ____Yes ____ No If yes, what year?______________

Are you participating in the Woman to Woman peer support program? ____Yes ____No

Name: ______________________________

Sue's Gift Application / Income Information

(Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.)

Monthly Wages

Your monthly wages after payroll taxes $____________
Spouse or partner's monthly wages after payroll taxes $____________
Other monthly income from wages or self-employment $____________

Monthly Income from Benefits & Insurance

Employer disability insurance $____________
Unemployment insurance $____________
Retirement / Pension $____________
401K / IRA income $____________
Social Security $____________
SSI / SSDI $____________
Other benefits/Insurance $____________
Income from assistance alimony / Child support received $____________
Low-Income Energy Assistance Program (LEAP) $____________
Food Stamps (SNAP) $____________
Temporary Aid to Needy Families (TANF) $____________
Aid to the Needy and Disabled (AND) $____________
Section 8 from HUD (housing supplement) $____________
Help from family members $____________
Help from religious / faith community $____________
Help from friends $____________
Help from other nonprofit organizations $____________
Other Assistance $____________

Assets		Monthly Income from Assets
Cash / Checking Value:	_____________	$____________
Savings Value:	_____________	$____________
Life insurance value:	_____________	$____________
Investments value:	_____________	$____________
Real estate value: (Not the house you live in)	_____________	$____________

TOTAL CURRENT MONTHLY INCOME: $____________
(Please total all monthly income listed above.)

(Revised 3/2021)

Name: ______________________________

Sue's Gift Application / Expenses Information

Monthly Household Expenses

Rent $____________
Mortgage $____________
Energy bill $____________
Water bill $____________
TV / Internet / Cable / Satellite $____________
Telephone / Cell (including long distance) $____________
Food $____________

Monthly Dependent Expenses

Child care $____________
Child support paid $____________
Elder care $____________

Monthly Transportation Expenses

Car payment $____________
Gasoline$____________
Car insurance $____________
Parking / Public transportation $____________

Monthly Medical Expenses

Health insurance premiums$____________
Medical costs (after Insurance) $____________
Medication costs (after insurance) $____________

Monthly Loan Expenses

Loan payments $____________
Credit card payments $____________

Other Expenses

Other:______________________ $____________
Other:______________________ $____________
Other:______________________ $____________

TOTAL CURRENT MONTHLY EXPENSES: $____________
(Please total all monthly expenses listed above.)

If you currently seeking any other assistance for outstanding expense payments, please explain:

____

(Revised 3/2021)

Name: ____________________________

Sue's Gift Application / Gynecologic Cancer History

Date Diagnosed__________ Type of Gynecologic Cancer__________________ Stage_______

Have you experienced a recurrence? _______ Have you seen a Gynecologic Oncologist?______

Have you participated in a clinical trial?_________ Treatment Facility________________________

Surgeon _________________________________ Oncologist _____________________________

Social Worker_________________________ Nurse / Navigator____________________________

Please check your reason for applying for financial assistance:

____ To help pay an annual health insurance deductible
____ To help pay for a prescription
____ To help pay for a psychiatrist
____ To help pay for other medical expenses
____ To help pay housing expenses (rent or mortgage)
____ To help pay for utilities
____ To help pay for car payments

Read and check the lines to verify the following information:

____I have read Page 1 and understand how and who Sue's Gift helps with financial assistance.
____I live in Southern Colorado.
____I am participating in the Woman to Woman peer support program.
____I have enclosed proof of residency.
____I am currently undergoing chemotherapy or other oncologist-directed treatment for gyn cancer.
____I am currently within three months of gynecologic cancer-related surgery, chemotherapy, or oncologist-directed treatment.
____I have signed the bottom of this page, which serves as a medical release giving Sue's Gift permission to obtain the necessary medical information to process my application.
____I understand that Sue's Gift will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview.
____I understand that the Sue's Gift provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release Sue's Gift from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize Sue's Gift to release any information including my name, address, and type of assistance provided to any other social service agency at Sue's Gift's discretion. I also authorize the release of any medical information and documentation required by Sue's Gift for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.

Applicant's Signature_____________________Print Name____________________Date: _______

Healthcare Provider: Please complete and mail, email, or fax to Sue's Gift. Thank you for your assistance.

Mail: Sherry Martin, LCSW
Sue's Gift
525 N. Cascade, Suite 213
Colorado Springs, CO 80903

Email: sherry@suesgift.org **Phone:** 719-422-9964 **Fax:** 719-264-1094

Sue's Gift Medical Verification

Patient name ____________________________ Confirmed diagnosis________________________

Date of initial diagnosis __________Stage__________ Cell type________________ Grade_________

Patient is currently seeing a Gynecologic Oncologist ____Yes ____No Name ________________

Patient is currently seeing a Medical Oncologist ____Yes____ No Name ___________________

Patient is currently being treated for a recurrence ____Yes____No Recurrence date__________

Patient has undergone surgery ____Yes ____No Most recent surgery date _________________

Patient has a planned surgery ____Yes ____No Planned surgery date ___________________

Surgical procedure ____

Patient is currently undergoing chemotherapy ____Yes ____No

Chemotherapy start date_________________ Anticipated end date______________________

Drug __________________________________ Drug ___________________________________

Patient is currently undergoing radiation therapy ____Yes ____No Dates____________________

Patient is being admitted to a clinical drug trial ____Yes ____No

Clinical trial start date ____________________ Anticipated end date__________________

Other planned treatment(s) or important medical information about this patient's gynecologic cancer treatment____

Referring licensed professional completing this form: (MD, DO, PA, NP, RN, RN or LCSW)

Name & Credentials ____________________________ Hospital/Clinic ________________________

Address ____ City ___________________________

State _______Zip_________Phone (   )________________Email____________________________

My signature below affirms the diagnosis and treatment information as described on this page.

Referring professional signature____ Date ____________

(Revised 3/2021)