STAFF ONLY
Date/Time Received:

Sprout Love Financial Assistance Fund Application

APPLICATION CHECKLIST:

In order to make sure that your application is eligible for consideration, please check that **all** of the following documents are included:

- ☐ Completed Sprout Love application:
  - ☐ Application checklist
  - ☐ Personal information
  - ☐ Medical information
  - ☐ Statement of income
  - ☐ Expense information
- ☐ A signed and dated letter (on letterhead) confirming your diagnosis **and received active cancer treatment** within the last year from a medical professional on your treatment team (*please select one of the following*):
  - ☐ Physician, nurse practitioner, or physician assistant
  - ☐ Nurse navigator
  - ☐ Patient navigator
  - ☐ Social worker
- ☐ Proof of residence (*e.g. utility bill, copy of ID, drivers license, or like documentation*)
- ☐ Copies of bills or receipts which you wish to be considered for payment (*please do not send originals*).

Please submit your application via email to sproutlove@cancersupportannarbor.org, fax to 734-975-2525, or mail to:

Cancer Support Community of Greater Ann Arbor
Attn: Financial Assistance
2010 Hogback Rd. Suite 3
Ann Arbor, MI 48105

CONTACT INFORMATION:

Name: _____

Address:

_____

_____

Preferred phone: _____

Secondary phone: _____

Email address: _____

MEDICAL INFORMATION:

Were you or a member of the household in active treatment for cancer within the past year?

- ☐ Yes
- ☐ No

Person diagnosed with cancer:

- ☐ Self
- ☐ Family member

  Name: _____

  Relationship: _____

Person diagnosed with cancer's date of birth: _____

Type of cancer: _____

Stage:

- ☐ 0
- ☐ I
- ☐ II
- ☐ III
- ☐ IV

Date of diagnosis: _____

If recurrent, date of recurrence: _____

Currently in active treatment?

- ☐ Yes
- ☐ No
  Date completed: _____

Treatment to date (please check all that apply):

- ☐ Surgery
- ☐ Chemotherapy
- ☐ Radiation
- ☐ Hormone therapy
- ☐ Immunotherapy
- ☐ Other: _____

Cancer treatment center: _____

Treating physician's name and office phone number: _____

_____

STATEMENT OF INCOME:

Total number of people in the household: _____

Number of working adults in household: _____

Number of children/dependents in household: _____

Monthly household income **before expenses**:

_____

EXPENSE INFORMATION:

Each application to the Sprout Love Financial Assistance Fund may cover bills and receipts totaling up to the $2000 annual cap per household. The program covers basic living expenses including, but not limited to: rent/mortgage, phone, internet, electric/gas, car payment, childcare, groceries, and transportation. Copies of bills/receipts for which assistance is requested are required for consideration, although payments are made directly to the applicant. Please attach copies of supporting bills or receipts—*please do not attach originals.*

We cannot consider payment for any expenses without an attached bill or receipt. Any requested assistance without a bill matching the *exact* amount listed below will be removed, and the total amount requested will be adjusted accordingly.

Requested assistance:

- ☐ Rent/mortgage $_____
- ☐ Phone $_____
- ☐ Internet $_____
- ☐ Electric/gas $_____
- ☐ Car payment $_____
- ☐ Childcare $_____
- ☐ Auto Insurance $_____
- ☐ Groceries $_____
- ☐ Other _____ $_____

Total amount requested: $_____

DEMOGRAPHIC INFORMATION:

The following questions are optional and will in no way affect your eligibility for Sprout Love Financial Assistance.

Race (please check all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic

Gender:

- ☐ Man
- ☐ Woman
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Nonbinary
- ☐ Other: _____

CERTIFICATION AND CONSENT:

I hereby certify, under penalty of perjury, that the information set forth on this application is true and accurate and that the expenses for which I have requested financial assistance impose a financial hardship for me. Further, myself or my loved one has been diagnosed with cancer, I/they are undergoing treatment for, or are in recovery from recent treatment for cancer, and do not have adequate resources or income to pay for the expenses. I understand that if any of the information set forth above is false, that my application will be null and void. Additionally, I understand that any tax implications are my responsibility and the Cancer Support Community does not provide any information directly to me for tax purposes.

By signing below, I hereby grant and give permission for representatives of the Cancer Support Community of Greater Ann Arbor to contact my physician(s) and/or medical team member(s) as needed.

Signature _____ Date _____