

STAFF ONLY

Date/Time Received:



Cancer Support Community's 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 applications are reviewed on the second and fourth Wednesday of every month. ***Incomplete applications will not be reviewed.***

- ☐ Completed Sprout Love application:
 - ☐ Personal information
 - ☐ Medical information
 - ☐ Signed Statement of income Statement of income (at or below 400% of poverty as defined by the current federal poverty level)
 - ☐ 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 within CSC service area (i.e. – utility bill, driver's license, Michigan ID or like documentation). The service area includes Washtenaw, Livingston, Western Wayne, Jackson, Lenawee, Monroe, and a portion of Genesee counties. A full list of zip codes included in the service area is available on our website.
- ☐ Copies of bills or receipts which you wish to be considered for payment

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

Questions? Call 734-975-2500 or email sproutlove@cancersupportannarbor.org

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

☐ II

☐ IV

☐ I

☐ III

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

☐ Hormone therapy

☐ Chemotherapy

☐ Immunotherapy

☐ Radiation

☐ Other: _____

Cancer treatment center: _____

Treating physician's name: _____

Treating physician's 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 \$2,000 annual cap per household per year. The program covers basic living expenses including, but not limited to: rent/mortgage, phone, internet, electric/gas, car payment, childcare, groceries, and transportation. **This fund does not cover health care expenses. Other assistance programs exist to help with health care expenses. Please talk to your oncology social worker or call CSC to get referral information.**

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: \$ _____

CHECK DISBURSEMENT PREFERENCE

If your application is approved, how would you like to receive your check?

☐ Mail it to my address on application

☐ I will pick it up at the office

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 Identity:

- ☐ 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 _____