# CANCER ANGELS OF SAN DIEGO

1915 Aston Avenue, Carlsbad, CA. 92008

PHONE: (760) 942-6346 FAX (760) 683-3088 www.cancerangelsofsandiego.org


## CLIENT APPLICATION

Candidates applying for financial assistance must have a diagnosis of Metastatic Cancer, Stage IV. and reside in San Diego County

Please read the following instructions before beginning the application.

1. Complete application in full. Be as specific as possible with regard to income and expenses, savings, and other forms of assistance to which you may have access. Please initial the bottom of every page where indicated.
2. Pages 5 and 6 are two copies of an authorization for release of your medical information by your doctor. Fill this form out completely, and give one copy to your doctor (oncologist, surgeon - whomever you consider to be the head of your medical team). This form tells your doctor that you give him/her permission to provide information about you to Cancer Angels of San Diego and should be kept in your file. Please send one copy to Cancer Angels of San Diego along with your application.
3. Have your physician complete page 7, which will tell Cancer Angels of San Diego about your cancer diagnosis and treatment plan. He/she may complete the form and return it to you, or complete it and mail it directly to Cancer Angels of San Diego..
4. Submit your application to Cancer Angels of San Diego by mail or fax. Please note: Your application will not be processed until complete, including receipt of the physician report .

| ELIGIBILITY | |
|---|---|
| | |
| **Identification** | Must provide proof of identification. Picture ID, CDL, California ID, passport, employment or school ID, or other acceptable identification and social security card. |
| **Housing** | Must provide Proof of location of residence by rent receipt, mortgage payment receipt or contract, or note from landlord; utility receipts, turn-off notice, late notice, eviction notice, fore-closure notice, 3 day notice to quit, etc. |
| **Income** | Must provide verifiable income information. Earned and unearned income for spouse or other responsible persons living in the home. |
| **Medical statement** | Must provide current diagnosis, prognosis, and treatment plan with date and signature of treating physician |
| **Property** | Must provide information about owned property including liquid resources, real estate, vehicles, etc. |
| **Non-shelter expenses** | Must provide information about credit payments, car payments, child care, child support, cable, furniture storage, health club, other legal obligations for spouse or other responsible persons living in the home |
| **Vehicles** | Exempt |
| **Liquid resources** | Must demonstrate that available liquid resources are below $1,000 total limit; includes bank accounts, stocks, bonds and any other accessible items that can be readily converted. Inaccessible resources are exempt. |
| **Real estate** | Exempt for the first home only. |
| **Personal items** | Exempt |

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**Date of Application** ________________________________

**DEMOGRAPHIC INFORMATION**

Name: __________________________________________________ Date of Birth: _________________________

Address: _____________________________________________________________________________________

City, State Zip: _______________________________________________________________________________

Phone number: Home: _____________________________________ Work: ______________________________

Cell Phone: _________________________________ Other: _______________________________

E-Mail: __________________________________________________________________________

Ethnicity (optional): ______________________________________ Preferred Language: ____________________

**MARITAL STATUS (please circle)**

1. Married 2. Never Married 3. Separated 4. Divorced

5. Widow(er) 6. Other ____________________________________________________________

**CHILDREN**

| Name | Age | Birth Date | Gender (circle F or M) | Residence (circle Y or N) |
|---|---|---|---|---|
| 1. | | | F M | Lives with you? Y / N |
| 2. | | | F M | Lives with you? Y / N |
| 3. | | | F M | Lives with you? Y / N |
| 4. | | | F M | Lives with you? Y / N |
| 5. | | | F M | Lives with you? Y / N |
| 6. | | | F M | Lives with you? Y / N |

| Other Dependents Living With You | | |
|---|---|---|
| Name | Age | Relationship to You |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

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What medical insurance do you have? (Private, Medicare, MediCal, BCCTP, etc.) ___________________________

_______________________________________________________________________________

Current cancer diagnosis – please include stage and treatment plan (in your own words)____________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Tell us your reasons for making this application: ______________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Did someone help you with this application? ☐ No ☐ Yes

Name: _________________________________ Relationship: ______________________________

Phone Number: ___________________________ Email:_________________________________

Please list your physicians below, including name and phone number:

Medical Oncologist: ______________________________________________________________

Radiation Oncologist: _____________________________________________________________

Surgeon: _______________________________________________________________________

Plastic Surgeon: _________________________________________________________________

Please provide us with an emergency contact. The person you list should be someone that you are in contact with on a regular (daily or weekly) basis that we can call if we are unable to reach you.

Name: ______________________________________ Relationship to you: ________________________

Home phone number: ___________________________ Cell phone number: _________________________

E-mail Address: __________________________________________________________________

Please use this space to add any comments or information you would like to tell us: ____________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

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**WORK HISTORY**

Most recent employer: ___________________________________ Job title: _________________________________

If not currently working, date last worked: ____________ Monthly income when working: __________________________

| **CURRENT INCOME** | | **Monthly amount** |
|---|---|---|
| 1. Your wages/salary *if you are currently working* (after taxes) | | 1. $ |
| 2. Spouse/partner's wages/salary (after taxes) | | 2. $ |
| 3. Property rental income | | 3. $ |
| 4. Interest/dividends | | 4. $ |
| 5. Veterans Benefits | | 5. $ |
| 6. Roommate/Boarder | | 6. $ |
| 7. Other | | 7. $ |
| **Please indicate if you have applied for any of the following.**<br><br>**Circle "accepted" if you are receiving funding, "pending" if your application is in process, or "denied" if you have been denied for that program** | | |
| 8. Disability thru employer | Accepted Pending Denied | 8. $ |
| 9. State Disability Insurance | Accepted Pending Denied | 9. $ |
| 10. SSI/SSD | Accepted Pending Denied | 10. $ |
| 11. Other Soc. Sec. ____________________________________________ | Accepted Pending Denied | 11. $ |
| 12. Unemployment Insurance | Accepted Pending Denied | 12. $ |
| 13. Pension/Retirement | Accepted Pending Denied | 13. $ |
| 14. Worker's Comp | Accepted Pending Denied | 14. $ |
| 15. Child support/alimony | Accepted Pending Denied | 15. $ |
| 16. Care of foster child | Accepted Pending Denied | 16. $ |
| 17. In-home care/In-Home Supportive Services | Accepted Pending Denied | 17. $ |
| 18. School grants/loans | Accepted Pending Denied | 18. $ |
| 19. General Relief (Welfare) | Accepted Pending Denied | 19. $ |
| 20. Food Stamps | Accepted Pending Denied | 20. $ |
| 21. CalWORKS (AFDC) | Accepted Pending Denied | 21. $ |
| 22. Other ____________________________________________________ | Accepted Pending Denied | 22. $ |
| **TOTAL AVAILABLE MONTHLY INCOME (add lines 1-22 together):** | | $ |

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Do you have relatives, friends or religious groups available to help with basic necessities? ☐ No ☐ Yes
If yes, list all contacts made to obtain assistance if different from above (use a separate sheet if necessary):

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Are you receiving funds/loans/donations, etc. from any other social services agencies in your County? ☐ No ☐ Yes
If yes, list all agencies and dates and amounts of last aid (use a separate sheet if necessary):

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**LIQUID ASSETS**
Please list all relevant liquid assets (see page 1 for examples)

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**MONTHLY EXPENSES**

| | |
|---|---|
| 1. ☐ Mortgage or ☐ Rent | 1. $ |
| 2. Gas | 2. $ |
| 3. Electricity | 3. $ |
| 4. Water | 4. $ |
| 5. Trash Collection | 5. $ |
| 6. Telephone and/or cellular phone | 6. $ |
| 7. Cable | 7. $ |
| 8. Food | 8. $ |
| 9. Auto Loan | 9. $ |
| 10. Auto Insurance | 10. $ |
| 11. Gasoline | 11. $ |
| 12. Medications | 12. $ |
| 13. Medical co-payments and/or share of cost | 13. $ |
| 14. Health insurance premiums | 14. $ |
| 15. Other: | 15. $ |
| 16. Other: | 16. $ |
| 17. Other: | 17. $ |
| **TOTAL OF ALL MONTHLY EXPENSES (Add lines 1 through 17 together):** | **$** |

❑ Please check this box if you would like to be referred to other agencies for possible assistance. Referrals may result in sharing your information with other agencies.

By signing below, I agree that the above information is true and correct.

_______________________________ Signature

_______________________________ Date

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# APPLICANT AUTHORIZATION FOR RELEASE OF INFORMATION

To: ____________________________________________
Agency/Individual **From Whom** Information is Requested (e.g., your physician)

Address: ____________________________________________
____________________________________________
____________________________________________
____________________________________________

I, ______________________, residing at ______________________
____________________________________________
____________________________________________

hereby authorize you to release to Cancer Angels of San Diego, a non-profit organization (26-1099989) specific information requested by them which I cannot provide concerning:

____________________________________________
____________________________________________
____________________________________________
____________________________________________

This information is needed to determine my eligibility for assistance from them. I have read this form and have agreed to its request prior to my signing.

| ______________________ | ______________________ |
|---|---|
| Print name | Social Security Number |
| ______________________ | ______________________ |
| Date of birth | Birthplace |
| ______________________ | ______________________ |
| Signature of Applicant | Date |
| ______________________ | ______________________ |

**Note: Provide this form to the physician or other agency from whom you are requesting the release of information to Cancer Angels of San Diego.**

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Address: ____________________________________________

____________________________________________

____________________________________________

____________________________________________

I, ______________________________, residing at ______________________________________

____________________________________________________________

____________________________________________________________

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____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

This information is needed to determine my eligibility for assistance. I have read this form and have agreed to its request prior to my signing.

| | |
|---|---|
| ______________________ | ______________________ |
| Print name | Social Security Number |
| ______________________ | ______________________ |
| Date of birth | Birthplace |
| ______________________ | ______________________ |
| Signature of Applicant | Date |
| ______________________ | ______________________ |

# PHYSICIAN REPORT

The individual listed below has requested financial assistance from Cancer Angels of San Diego and has stated that s/he is unable to work or is unable to work at pre-treatment level. A signed release for the requested information is attached.

Please complete this form and return it by: ____________ (date)

**Attn: Client Services**
**Cancer Angels of San Diego**
**1915 Aston Avenue**
**Carlsbad, CA. 92008**
**FAX: 515-474-6258**

| **SECTION I** | | | |
|---|---|---|---|
| Name: | | | |
| Date of birth: | | Social Security #: | |
| Physician's Name: | | Physician's phone: | |
| Physician's Address: | | | |
| **SECTION II – TO BE COMPLETED BY YOUR PHYSICIAN** | | | |
| Diagnosis: | | | |
| Date of onset: | | Date of last appointment: | |
| Pertinent pathology results (attach copy of report if available): | | | |
| Medications prescribed: | | | |
| Indicate client's prognosis: | | | |
| Specific physical limitations: | | | |
| **Is patient's condition suitable for employment?** | | ☐ **Yes** ☐ **No** | |
| **What level of employment activity is suitable for patient?** | | ☐ Part-time ____ hours per week ☐ Full-time | |
| **Projected date patient can return to work at pre-treatment level:** | | | |
| **Planned surgeries – list date and expected date of recovery:** | | | |
| **Other planned treatments (chemo, radiation, etc.) – list projected end date:** | | | |
| Comments: | | | |
| Physician's signature: | | Date Signed: | |