RAY OF HOPE
CANCER FOUNDATION
Assisting Coloradans in Cancer Treatment

Applying to Ray of Hope for Financial Assistance

Ray of Hope provides two types of financial grants, an essential needs grant and a subsidy grant for households consider low income. The eligibility criteria for these two financial grants are different. You can use this application to apply to either the essential needs grant, the subsidy grant, or both if eligible for both. See the eligibility guidelines below to see if you are eligible to apply for assistance from one or both of our financial grants.

Essential Needs Grant

The essential needs grant provides $500 ($1,000 for pediatric patients) to Colorado cancer patients in active treatment and in dire financial circumstances. If you receive this award, the check will be made out in your name.

Do you meet the eligibility for the essential needs grant?

- I am 18 years or older or am the parent/guardian of a patient under 18.
- I am a Colorado resident.
- I have a cancer diagnosis.
- I am currently receiving cancer treatment that includes chemotherapy, targeted therapy, immunotherapy, radiation orsurgery, or I have completed one of these treatments within the past month.
- I have a dire financial circumstance (expenses must be greater than income to meet this eligibility requirement)

*If you have answered **YES** to **every** question, you are eligible to apply for assistance from the unrestricted fund.*

Subsidy Grant

(based on household income)

The subsidy helps cancer patients who qualify as low-income families earning 175% or less of the Federal Poverty Level. Assistance is for rent, mortgage, utilities, telephone, car payment, health insurance, and other essential expenses. If you receive this assistance, the check will be made out in your name.

Do you meet the eligibility criteria for the guaranteed assistance subsidy?

- Same as essential needs grant
  - I am 18 years or older.
  - I am a Colorado resident.
  - I have a cancer diagnosis.
  - I am currently receiving cancer treatment that includes chemotherapy, targeted therapy, immunotherapy,radiation, or surgery, or I have completed one of these treatments within the past month.
  - I have less than $5,000 in liquid assets.
  - I have a dire financial circumstance (expenses must be greater than income to meet this eligibility requirement)
- With the addition that the **gross** income for everyone in the household does not exceed the income guidelines below

Income Guidelines

# in Household	Gross Monthly Income
1	$1,732
2	$2,336
3	$2,940
4	$3,544
5	$4,148
6	$4,752
Add $604 for each additional person	

*If you have answered **YES** to **every** question, you can apply to receive the subsidy grant.*

Contact Information:
1385 S. Colorado Blvd, Suite 108
Denver, CO 80222
grants@rayofhopecolorado.org
Phone: 303.835.2568
Fax: 303-499-9229

PATIENT NAME:_____

MEDICAL VERIFICATION FORM: THIS PAGE MUST BE COMPLETED BY A REFERRING PROFESSIONAL

Do not use abbreviations or codes for diagnosis and treatment. Do not send medical records. 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)*:

☐ Surgery Type: Date of Surgery:

☐ 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 Ray of Hope before? ☐ YES ☐ NO

Grant applying to:

☐Essential Needs Grant ☐Subsidy Grant ☐Both the Essential Needs & Subsidy Grant

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 the form*):

Facility:

Address:

City: State: ZIP:

Phone: ( ) E-mail:

Referring professional's summary regarding patient and their household's financial situation:
(This is required, please include as an attachment as needed)

Must be signed by referring professional *(caseworker, patient navigator, social worker, nurse, physician)*

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

Signature: Date:

PATIENT NAME:_____

PERSONAL DATA —TO BE COMPLETED BY GRANT APPLICANT *(or parent/guardian if the patient is under 18)*
Answer each question thoroughly. 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			
Gender Identification: □ Man □ Woman □ Trans* □ Non-binary □ Other:			

The questions in this section are optional, and your answers are confidential. This information is reported generally and anonymously to help policymakers and advocates better understand and address health disparities in underserved groups. Occasionally, additional funds may be available for some under-served groups.

Sexual Orientation: □ Bisexual □ Gay/Lesbian □ Heterosexual □ Other

Ethnicity: □ African American or Black □ Asian or Pacific Islander □ Hispanic □Native American
☐ White (non-Hispanic) □ Other_____

Education: □ Grade school □ High school □ Vocational school □ College □ Graduate □Post-graduate

Preferred language:

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)

PATIENT NAME:_____

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).

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) V.A. 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	$		

EXPENSES — TO BE COMPLETED BY GRANT APPLICANT

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

Expense	**Payment/Amount**	**Priority of Need**
1. How much a month do you pay for housing expenses (rent, mortgage, HOA fees, property taxes, etc.)	$	
2. How much a month do you pay for living expenses (groceries, utilities, cell phone, T.V., internet, etc.) Make sure to include Monthly food expense*: **$200/m x # in house =**	$	
3. How much a month do you pay for debt-related expenses (car payments, credit cards, student loans, etc.)	$	
4. How much a month do you pay for medical expenses (premiums, copays, prescriptions, etc.)	$	
5. Other expenses	$	
Total Monthly Expenses	$	

*Describe other expenses from line ***5*** here (you can also use this space to clarify anything you'd like about your expenses):

PATIENT NAME:_____

GRANT REQUEST APPLICATION —TO BE COMPLETED BY GRANT APPLICANT

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

Summarize your current financial situation **(this is required).**	
I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize Ray of Hope Cancer Foundation to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my case that might help assess my application. *I release Ray of Hope Cancer Foundation of all liabilities or claims arising from the donation of money or servicesprovided to me or my family.*	
Applicant's Signature:	Date:

APPLICATION CHECKLIST:

- ☐ My name is on every page of this application.
- ☐ 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 *(page 4)*.
- ☐ I have attached copies of household income (recent pay stubs, social security letters, pension statements, etc.)
- ☐ I have attached copies of household bills (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