CANCER ANGELS OF SAN DIEGO
2240 Encinitas Blvd., #D, P.O. Box 327, Encinitas, CA 92024
Phone: (760) 942-6346 Fax: (760) 683-3088 website: www.cancerangels.org

CLIENT APPLICATION

Candidates applying for financial assistance must have a diagnosis of Metastatic Cancer, Stage IV and legally 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. An authorization for release of your medical information by your doctor is required. Fill this form out completely and give one copy to your doctor (oncologist, surgeon - whomever you consider to be the head). This form tells your doctor that you give him/her permission to provide information about you to Cancer Angels of San Diego and will 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. You may also fax it to 760-683-3088.
4. Submit your application to Cancer Angels of San Diego by mail, email or fax. Please note: Your application will not be processed until it is complete, including receipt of the physician report.
5. You must include all back up documents. Your application will be processed once all documents are received.

ELIGIBILITY	
Identification	Must provide proof of identification. Picture ID, 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, foreclosure notice, 3-day notice to quit, etc.
Income	Must provide verifiable income information, earned and unearned income for you 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 you or other responsible persons living in the home
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. Do not list.
Personal items	Exempt. Do not list.

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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.		

Initial here_____

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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: _____

_____

_____

_____

_____

Initial here_____

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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. **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/EBT card	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):		$

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

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).
Also, list all GOFUNDME and other donated accounts.

Initial here_____

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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):

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 (office visits, lab costs, etc.)	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 _____

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

Initial here_____

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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 diagnosis, prognosis, treatment:

_____

_____

_____

_____

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.

Initial here_____

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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 to:

Attn: Client Services
Cancer Angels of San Diego
2240 Encinitas Blvd., #D, P.O. Box 327
Encinitas, CA 92024
FAX: 760-683-3088

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:		Stage:	
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:	

Initial here_____