FamiliesCAN Application for Financial Assistance

March, 2012

A Note to Prospective Applicants:

Thank you for your interest in our program. I know that we are making contact with you during a very trying period of your life. I understand because I too have had a loved one who has faced cancer. When my daughter was a newborn, my husband fought cancer for the third time. His treatment took place at U.C.L.A. Medical Center -- we flew back and forth with our new baby for nine months and lived out of a suitcase at the Holiday Inn. Today, fourteen years later, Bruce enjoys good health. He does karate three times a week and keeps up with our daughter Anna, a dancer, and our son Andrew, a Boy Scout who likes to camp out in the snow with his dad.

I have been running this program since 2000. With the help of our wonderful Program Director, Eduarda Francisco, we have helped more than 500 families as they have made their way through cancer treatment. Beginning in 2012, Eduarda is moving on. I will be managing FamiliesCAN myself and opening the program for only a short time during the year in the spring. We will be helping fewer families than we have in the past. If you are unable to contact me, it's because I do this part-time as a volunteer. The foundation has no employees. This ensures that the money in the foundation is directed to the proper place: into the pockets of the patients themselves. It also means, however, that it will be difficult to connect with someone in person. Calls or e-mails that are received outside of the "window" in springtime when I am focused on FamiliesCAN may go unanswered, and e-mail will be returned sporadically.

If you are able to access this application from our website, it means that the program is "OPEN" and you may submit an application. If the program is "CLOSED" we have taken in enough applications for the year and are in the process of evaluating them -- or, we have dispersed our funds for the year and will be making no further gifts. Once the program is closed, you will find that this application can no longer be accessed.

The application form is to be completed electronically. Please have all of the necessary information available when you sit down to complete this process. You will need to provide information related to both your medical condition and your finances (income and expenses). If you don't finish the application in one sitting, you can save it to your desktop and retrieve it at a later date. When you get to the end of this application, you may want to print a hard copy before sending to ensure that you have backup documentation.

Before you begin, please be sure that you meet the program criteria listed on the website's "Who Is Eligible" page. We DO NOT make exceptions to these application standards, so please do not complete the form unless you qualify.
Here's a review of the criteria:

* Must have dependents who live with you who are age 18 or under
* Must be 65 years of age or younger
* At the time we review your application (the review period begins each spring), must be in treatment, have concluded treatment within the past two months, or scheduled to being treatment within the next two months
* Must live in Santa Clara or San Mateo County, and must have resided there for a minimum of one year
* Must be treated for cancer in Santa Clara County
* Must be a U.S. citizen

If you are selected for the program, you may be asked to verify information on the form. Prior to disbursing funds, all applicants will be asked to submit the following: 1) proof of U.S. citizenship 2) photo of patient and/or family (this is simply to have a visual cue for the family -- unfortunately, having helped 500 families; it becomes hard to recall each one without a photo).

Our selection criteria include the following: indebtedness due to cancer treatment; situations related to caring for dependents; short- and long-term diagnosis; general circumstances related to the family and employment. What we are trying to glean from your application is the overall burden that the family is facing as a result of the diagnosis. Please submit a complete application so that we can understand your particular situation. If there is information that you are unable to provide, please explain why. Applications that do not adequately communicate the needs of the family will not be funded.

In past years, most families who showed a need were offered assistance. Moving forward, our funds are constrained such that some truly needy families will not receive gifts. If we are not able to help, please know that it is not because of indifference on our part. We know that every diagnosis is devastating. I wish we could help every last person who applies.

Again, thank you for your interest in FamiliesCAN. Please be sure to check the "Resource" page on our website as these are lists of the best resources that we have identified over the past twelve years.

My best wishes to you for good health,

Jackie Whittier Kubicka
Director and Founder, FamiliesCAN

Date of Application: _____

PERSONAL INFORMATION

Name of Patient: _____

Female: _____ Male: _____

Date of Birth: _____

Age: _____

Are you a U.S. Citizen? _____

(Note: if you are not a U.S. Citizen, please do not complete this application)

Address: _____

City, State, and Zip: _____

County: _____

(Note: if you have not resided in Santa Clara or San Mateo County for at least one year, please do not complete this application)

How long have you lived in this county: _____

How long have you lived at this location? _____

Phone: _____

E-mail: _____

Is this your home your permanent residence? _____

If not, where is your permanent residence? Please explain.

_____

Do you live with extended family? _____

If yes, with whom? _____

In your home or theirs? _____

How long have you lived in the Bay Area? _____

Is there anything you want to tell us regarding your length of residence here in the Bay Area, or your move to the Bay Area?

_____

Please list the members of your immediate family with whom you live. Include spouse or partner, and list ages for all children: (i.e. John Doe, Son, 13 / Mary Doe, Daughter, 5)

_____

(Note: if you do not have children 18 years of age or younger, please do not complete this application)

Please list additional members of your immediate family with whom you do not live. Please list their name, age, relationship to you and whether or not they are a dependent (i.e. Jerry Dependent, Son, 11 Kathy Dependent, Daughter, 8)

_____

If you have recently gone through a major transition with regard to your immediate family (separation/divorce/death of spouse or partner) you are welcome to share this with us:

_____

Name of your primary caregiver:

_____

Relationship (spouse, partner, parent, sibling, etc.): _____

If there is anything we should know about your caregiver's ability to care for you, please explain:

_____

Name of individual completing this application:

_____

Is the patient available to speak with us over the phone regarding this application?

_____

If the patient is unavailable, with whom may we communicate regarding this application?

_____

Please list the phone number of this alternate contact: _____

Please list the e-mail address of this alternate contact: _____

Were you referred to our program? _____

By whom? _____

If you were not referred, how did you learn about our program?

_____

FAMILY INFORMATION

Please tell us about your children. Please note that in order to participate in our program, you must have at least one child age 18 or under.

Name of Child : _____

Age: _____

School Name: _____

Public or Private: _____

Distance of school from your home: _____

Name of Child : _____

Age: _____

School Name: _____

Public or Private: _____

Distance of school from your home: _____

Name of Child : _____

Age: _____

School Name: _____

Public or Private: _____

Distance of school from your home: _____

Name of Child : _____

Age: _____

School Name: _____

Public or Private: _____

Distance of school from your home: _____

Are you the parent, legal guardian, grandparent with legal custody or grandparent without legal custody of these children?

_____

If you are the grandparent and do not have legal custody of the children, please explain the circumstances under which you have come to care for the children. Please also indicate for how long the children have been living with you.

_____

Do your children live with you full-time? _____

If not, how often do they live with you?

_____

Who is involved in the care of the children during your treatment? Please explain their role and frequency of their interaction.

_____

Do you have older children (ie, older than 18) who are still dependents? _____

If you have children with special needs and would like to share this, you are welcome to do so (you might also indicate how the children are cared for and whether the patient is primary or secondary caregiver)

_____

Is there anything you wish to tell us about your children?

_____

MEDICAL INFORMATION

Date Of Initial Diagnosis: _____

Is this a Reoccurrence? _____

Date of Diagnosis of Reoccurrence: _____

Date Treatment Started (or is planned to start): _____

Date Treatment Ended (if applicable) or Is Scheduled to End (if unknown type "unknown") _____

(Note: if you are not having treatment, or within two months of starting or ending treatment, please **do not complete** this application)

Cancer Diagnosis (breast, leukemia, etc.) _____

Cancer Sub-Type (for leukemia, for example: ALL, CML, CLL, AML, etc) _____

This program requires patients to have treatment in Santa Clara County. Please list all facilities in Santa Clara County where you are currently being treated:

Location #1

Location: _____

Doctor: _____

Specialty: _____

Current or Future: _____

Additional Notes:

_____

Location #2

Location: _____

Doctor: _____

Specialty: _____

Current or Future: _____

Additional Notes:

_____

Location #3

Location: _____

Doctor: _____

Specialty: _____

Current or Future: _____

Additional Notes:

_____

Is any of your treatment (or will any of your treatment) take place outside of Santa Clara County? If so, what/when/by whom/frequency of treatments?

_____

Are you currently hospitalized or in a care facility? If so, list facility

_____

Are you currently or will you be restricted to a sterile environment for your treatment (as in the case of bone marrow transfer, etc.)?

For how long? _____

Have you had surgery or surgeries for this illness? _____

Please list the dates and give general description:

Date	**Description**	**Length of Hospital Stay**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is surgery planned for the future? Please explain and give dates, if known:

_____

Have you had chemotherapy for this illness? _____

Start Date	**End Date**	**Description**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have not had chemotherapy, is it planned? _____

If it is planned, what is expected start date? _____

How frequent will the treatments be? Daily/weekly, or at what interval?

_____

How long will the overall course of chemo treatment be_____

Will chemotherapy treatments be outpatient (ie, you just go for the day) or will you be hospitalized?

_____

Have you had radiation therapy for this illness? _____

Start Date **End Date** **Description**

_____ _____ _____

_____ _____ _____

_____ _____ _____

If you have not had radiation, is it planned? _____

If it is planned, what is expected start date? _____

How frequent will the treatments be? Daily/weekly, or at what interval? _____

How long will the overall course of radiation treatment be? _____

Will radiation treatments be outpatient (ie, you just go for the day) or will you be hospitalized?

_____

Are you involved in any other type of medical treatment for this illness (rather than, or in addition to, surgery/chemo/radiation):

_____

Are you being treated for illnesses other than the cancer that are related to the cancer? _____

Are there other details regarding the illness that you wish to share with us?

_____

Are there any other health-related concerns (not necessarily related to the cancer, but related to your overall well being) that you would like to share with us?

_____

How do you/will you get to treatment?

_____

FINANCIAL INFORMATION

The following questions relate to your income:

Who, among your family members, contributes to your income:

_____

Patient's Employer: _____

What Is Your Occupation? _____

Length Of Employment? _____

Are you working full-time or part-time? _____

Were you working full-time or part-time prior to diagnosis? _____

Have your hours changed since diagnosis? How so?

_____

Are you on a temporary leave of absence? _____

Are you being paid during your temporary leave of absence? _____

For how long has the absence been authorized? _____

If you are not working, what was your previous job and/or what is your profession?

_____

What was date of your last employment? _____

If you are not working, is unemployment due to this illness, or other?

_____

Do you expect to return to work? _____ When? _____

Do you expect to return to the same line of work, or other?

_____

What more would you like to tell us to help us understand your employment situation?

_____

Spouse/Partner

Who is your spouse's employer? _____

What is your spouse's occupation? _____

Length of Employment? _____

Is your spouse/partner working full-time or part-time? _____

Was he/she working full-time or part-time prior to your diagnosis? _____

Have his/her hours changed since diagnosis? If yes, how so? _____

Is he/she on a temporary leave of absence? _____

Is he/she being paid if on a temporary leave of absence? _____

How long has the absence been authorized? _____

If he/she is not working, what was his/her previous job and/or what was his/her profession?

_____

Do you expect to return to work? _____ When? _____

Does he/she expect to return to same line of work, or other? _____

What more would you like to tell us to help us understand his/her employment situation?

_____

OTHER SOURCES OF INCOME:

Do you receive disability payments from the state and / or private insurance? _____

If yes, monthly amount? State: _____ Private Insurance: _____

Do you receive permanent disability? _____

If yes, monthly amount: _____

If you are not receiving disability, have you filed for disability (but are awaiting the start of benefits)? _____

If you have not filed for disability, do you plan to file? _____

Do you receive Workers Comp benefits? _____

If yes, monthly amount: _____

Do you, or do your dependents, receive Social Security? _____

If yes, monthly amount: _____

Do you receive SNAP (Supplemental Nutritional Assistance Program)? If yes, monthly amount: _____

Are you collecting unemployment? If yes, monthly amount: _____

For how long have you collected unemployment? _____

Are your unemployment benefits expected to end? If yes, when? _____

Are you receiving child support? If yes, monthly amount? _____

Have you received grants from any other organizations? _____

If yes, which organization and dollar amount: _____

How is the money being used:

_____

What was your MONTHLY income during the year prior to your illness and what is your CURRENT income now (we are trying to get an idea of how much you were earning prior to diagnosis and whether your income has changed after diagnosis)

	PRIOR to the illness	**CURRENT**
Your income	_____	_____
Your spouse's income	_____	_____
Child Support	_____	_____
SNAP	_____	_____

	PRIOR to the illness	**CURRENT**
Unemployment benefits	_____	_____
Workers comp	_____	_____
Social Security	_____	_____
Disability	_____	_____
Other:	_____	_____
_____	_____	_____
_____	_____	_____
TOTAL	_____	_____

If the changes were not explained in a section above, please explain:

_____

The following questions relate to your expenses:

Do you: own a home; rent a home; rent an apartment; rent a room; live with extended family in their home; or "other"? (if other, please explain)

_____

For how long have you lived at this location? _____

Where did you live previously (and was this a house, apartment, etc. -- and, owned or rented)

_____

If your housing situation has changed or may change in the near future, tell us how it has changed, and why

_____

Please indicate whether any changes are a result of cancer treatment, or due to other circumstances (ie, if you have lost or stand to lose a home, was this already underway before diagnosis?)

_____

Do you live in Section 8 housing? _____

Do you own a home in which you are not currently living? _____

Where is this home in which you are not living located? _____

Are your mortgage payments current? _____

If not, how far are you behind? _____

Is your home in foreclosure? _____

What else would you like to tell us about your housing situation?

_____

This question pertains only to individuals who are hoping to use a grant to move to new housing: If you move to a new housing situation and your income is currently compromised, will you be able to make the mortgage/rent payments? Please explain:

_____

Please list the make and models of your cars:

Make	**Model**	**Year**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medical expenses have you incurred that is not covered by insurance. Please give dollar amounts so we understand the level of indebtedness (do not go and dig out receipts...just give us a general idea):

_____

What non-medical expenses have you incurred due to illness? (attendant care, temporary housing, driving to hospital, etc.)

_____

Do you have health insurance? _____

Do you have a deductible? _____

Are you carrying credit card debt? _____ If yes, how much? _____

Are you carrying debt from a loan or personal line of credit? _____

If yes, how much? _____

If your expenses exceed your income, how are you paying your bills?

_____

Have you recently filed for bankruptcy? _____

If “yes” please give date of filing _____

Has a bankruptcy order discharging your debts or establishing a payment plan gone into effect? _____

Do you have a savings account? _____

What is the balance of your savings? _____

Is savings accessible? _____

From what source was the savings derived (i.e. 401k, personal savings, etc.): _____

Have you/ your family members had to forgo any programs/activities/services due to a financial shortfall during cancer treatment?

_____

What, specifically? _____

Is there anything else you want to share with us that might better help us understand you financial situation?

_____

What are your general MONTHLY household expenses:

(NOTE: you do not have to give us all of your expenses -- just give us the major items)

Mortgage _____

Second Mortgage _____

Rent _____

Food _____

Childcare _____

Auto Payment _____

Auto Insurance _____

Education-related expenses _____

Other:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Total _____

YOUR SUPPORT NETWORK:

Are you working with a social worker at the hospital or treatment facility? _____

With whom? _____

At which treatment facility? _____

Are you or your children participating in support programs? If yes, which ones?

_____

PLEASE TELL US MORE ABOUT YOURSELF:

We look for families who have lived in, and contributed to, our local community here in Santa Clara County. Is there anything else you would like to tell us about yourself, your family, your life here in the Bay Area?

_____

Is there anything more that you wish to tell us about how cancer is affecting your family?

_____

PLEASE IDENTIFY YOUR SPECIFIC NEEDS:

If you are offered a grant, how will the money be used?

_____

ADDITIONAL REMARKS:

If there is anything that you need to tell us about any of the questions on this application, please note that here (ie, if there were any questions for which you did not have information, or were unable to understand or answer).

_____

PERSONAL / HEALTH INFORMATION RELEASE

The undersigned or the anticipated recipients of the funds wish to participate in the benefits provided by FamiliesCAN. We understand that our participation in such a program is wholly voluntary and that these benefits are provided by FamiliesCAN in furtherance of its humanitarian endeavor to provide financial support to families of cancer patients.

We hereby assume all risks and responsibility for any damage or injury, physical or emotional (including the aggravation of any existing illness or condition), which we or our family may sustain as a result of our participation in the benefits provided by FamiliesCAN, its volunteers, officers, directors, agents, sponsors, advisors, members, and employees.

We hereby release, discharge, indemnify, and agree to hold harmless FamiliesCAN, its volunteers, officers, directors, agents, sponsors, advisors, members, and employees, from all claims, demands, causes of action, present and future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by FamiliesCAN.

All information is and remains confidential. It will be used only: 1) in connection with the application process for the purpose of determining suitability of the applicant and 2) in the process of establishing services on behalf of the patient (school tuition, attendant care, etc.).

I hereby certify that all the information provided on this application is true.

☐ By checking this box, I am confirming that this is my signature

Date: _____

Authority to Release Hospital Records and/or Divulge Medical Information

Doctor/Hospital: _____

Social Worker/Hospital: _____

In regard to your patient named: _____

Age:_____ D.O.B: _____

I understand that I do not have to sign this form, but if I do not sign it my application for assistance from FamiliesCAN will be considered withdrawn. Failure to sign this form will not, however, affect my ability to obtain health care treatment, payment or health insurance benefits.

☐ By checking this box, I am confirming that this is my signature

Date: _____

PHOTO RELEASE

From time to time, FamiliesCAN hosts events, or partners with outside organizations by attending their events. Events are sometimes photographed and/or filmed. Photos are posted to our website (see the "Event Photos" section of our website for an example), occasionally used for printed materials, and in the case of a co-sponsored event, may be used by other organizations. By signing this photo release, you agree that FamiliesCAN or partner organizations may use photos of you and your family members for the website, printed materials, or other communications pieces, and that FamiliesCAN shall own these images.

We also ask that each patient submit a personal and/or family photo at the time that they are accepted into the program. This photo is to help us keep track of the more than 500 patients that we have helped. It will not be used for the purpose of communicating with the public unless explicit permission is requested by FamiliesCAN prior to use.

I, _____, have agreed to be photographed and/or recorded by FamiliesCAN, The Ronald Whittier Family Foundation and that they shall own all rights of every kind in said photography and/or recording.

☐ By checking this box, I am confirming that this is my signature

Date: _____

Print name: _____

Phone: _____

INSTRUCTIONS

After you've completed your form, please print the application form so that you have a hardcopy for your records. This can also be used for mailing in your application in the event that you are unable to upload your PDF file. **DO NOT GO TO ITEM #4 UNTIL YOU'VE COMPLETED STEPS 1-3.**

Once you've printed the form, please follow these steps:

1. Click on File
2. Choose 'Save As', then choose 'PDF'
3. Give your file a name and save it to your desktop. For example "John-Doe-FamiliesCAN.pdf"
4. Send an email to Jacqueline Whittier Kubicka and attach your completed PDF file to FamiliesCANprogram@sbcglobal.net