Financial Assistance Application
MUST BE A U.S. CITIZEN TO APPLY

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Age: _____ Number of Children (under 20 years old): _____

Ethnicity (optional): _____ Marital Status (optional): _____

Date of Diagnosis: _____Diagnosis:_____

_____

Oncologist: _____ May we contact your oncologist?_____

Are you currently undergoing active treatment (surgery, chemotherapy, and/or radiation)?_____

Please describe your treatment plan (surgery, chemotherapy, and/or radiation):_____

_____

Length of treatment (include specific dates and timeframe):_____

_____

Treatment Facility: _____ Insurance Provider: _____

Monthly Income:
Monthly Net Earnings (self & spouse): $_____ Past 12 Months Earnings (self & spouse): $ _____
Other Income (Explain: _____
(child support, alimony, rental income, 401k, etc.)
Do you own property other than you primary residence? _____
Checking Account: $_____ Savings Account: $_____
Have you received assistance in the past 12 months from other charitable organizations, churches, etc?
If yes, total amount received: $_____ From Whom? _____
TOTAL NET MONTHLY HOUSEHOLD INCOME: $ _____

Monthly Expenses:
Rent/Mortgage Payment: $_____ Phone: $_____ Cable: $_____
Electric/Gas: $_____ Water/Sewer: $_____ Food: $_____
Auto Payment: $ _____ Automobile Fuel: $_____ Auto Ins: $_____
Property Ins.: $_____ Property Tax: $_____ Heath Insurance: $_____
Life Insurance: $_____ Other Medical Expenses: _____
Other Expenses (List): _____
(child support, alimony, church tithe, etc.)
TOTAL MONTHLY EXPENSES: $_____

Employment:
Are you currently working (circle one)? Yes / No / Retired / Disabled

If not currently working, describe reason: _____

Employer: _____

Employer Address: _____Phone: _____

Short-Term Disability (circle one): Applied / Receiving / Not Applicable

Other Information:
What is your Primary financial need right now (select one)?

a. Mortgage/Rent Assistance
b. Utilities Assistance
c. Transportation Assistance
d. Groceries/Necessities Assistance
e. Other:_____

Please describe your request for assistance with household bills in detail and outline your need (include amounts of any past due bills). Medical bills are not an expense covered through The Meggs Foundation:

_____

_____

_____

Please describe how the onset of your medical treatment has impacted your ability to pay your bills – lost wages, limited ability to work, poor insurance coverage, etc.:

_____

_____

_____

_____

Please list your name if you are filling out this application on behalf of applicant: _____
State your relationship to the applicant and contact info: _____

_____

How did you hear about The Meggs Foundation? _____

Assistance Request / Applicant Statement / Release / Affirmation

I do agree to release to The Meggs Foundation II, Inc. ("The Meggs Foundation") or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance and as may be reasonably required to assist myself and my family. As an inducement to The Meggs Foundation to consider supplemental financial support in conjunction with the medical treatment of the applicant named above the undersigned does hereby affirm as follows:

1. The term "non-medical expenses" is understood to mean those reasonable and necessary expenses incurred by the family of the above-named Applicant or the above-named Applicant, in conjunction with that Applicant receiving medical treatment. Financial assistance will be provided, with the use of said funds to be specified by the Meggs Foundation. Bills cannot be in another person's name or be on an automatic payment system with creditor.
2. The undersigned acknowledges(s) and agree(s) to maintain records that will be made available to The Meggs Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.
3. **If my application is approved for further review by The Meggs Foundation, I will provide supporting documents for assistance requested such as.**

    - Copy of driver's license or state identification card;
    - Proof of patient eligibility; a letter of support from doctor, nurse or social worker;
    - Copy of bills to be paid (please submit photocopy of invoice to ensure financial assistance payment attributed to the correct account);
    - Photocopy of Bank statements from all adults residing in household (3 months);
    - Photocopy of most recent Federal Income Tax Return and W2 for all members of the household of working age;
    - Photocopy of last pay stub;
    - Any other applicable income for each individual living in the household including copies of statements for 401k's, IRA's, HSA's, HRA's, FSA's, stocks, bonds and any other, if they exist; and
    - Photocopies of current rental agreement or Lease.

    *Payments made for patients may require an IRS form W-9 to be completed by The Meggs Foundation.

The Meggs Foundation will pursue restitution for financial assistance if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance, and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

For good consideration which I acknowledge, I irrevocably grant to The Meggs Foundation II, Inc., ("The Meggs Foundation") and/or its subsidiaries, affiliates, representatives, assigns, licensees, and/or successors the right to use my story, my name, artwork, photographs, audiotapes, and/or letters that I provide of my child, my family, or myself in publications, slides, videotapes, motion pictures or on the internet, and in all forms and media including composite or modified representations for all purposes, including advertising, charitable solicitations, trade, or any commercial and/or charitable purpose throughout the world and in perpetuity. I waive the right to inspect or approve versions of any of the above listed used for publication or the written copy that may be used in connection with any images. The Meggs

Foundation is permitted, although not obligated, to include my name as a credit in connection with any images. I understand any visual images, story, letters or recordings may be primarily used to inform families, volunteers, donors, the media and general public about The Meggs Foundation programs, services, fundraising efforts, or events. I gladly give this authorization to support the efforts of The Meggs Foundation. I understand this authorization shall continue unless terminated in writing by The Meggs Foundation. I release The Meggs Foundation and The Meggs Foundation's subsidiaries, affiliates, assigns, licensees, directors and successors from any claims that may arise regarding the use of my image, including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright. The Meggs Foundation is not obligated to utilize any of the rights granted in this Agreement. Applicant's Name Date Signature

Dated this _____day of_____, in the year_____

_____

Applicant Signature

_____

Please Print Name