2319 N Webb Rd
Grand Island, NE 68803
(308) 675-0889

PATIENT INFORMATION (Please print clearly) Today's Date: _____

First Name: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Email Address: _____

Date of Birth: _____ Male _____ Female _____ Are you a veteran? _____

Social Security Number _____ Race: Caucasian Black/African Native American Hispanic/Latino

Asian/Pacific If patient is a minor (under 18), name of parent or guardian_____

Marital Status: Married Single Divorced Separated Cohabitate Widow

MEDICAL INFORMATION ***_**This section must be completed by your oncology nurse, doctor or hospital patient navigator**_***

Date of Diagnosis: _____ Primary Cancer: _____ Current Stage: _____

New Diagnosis: _____ Recurrence: _____ Is patient in active treatment? Yes No

If not in active treatment, indicate frequency of follow-up: Yearly_____ Monthly_____ Other _____

List types of treatment received in the past twelve months: _____

Health Care Professional Information and Signature

Doctor's Name: _____ City, State, Zip _____

Hospital/Clinic _____Phone: _____

Address: _____ Fax: _____

DOCTOR'S SIGNATURE _____

(3-2020) ***INCOMPLETE APPLICATIONS CANNOT BE ACCEPTED***

HOUSEHOLD FINANCIAL INFORMATION
(Please do not leave any information blank. Household income listed below)

Are you currently? Employed Retired Student Other

Number of immediate family members in household? _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Name: _____ DOB: _____/_____/_____
Relationship: Spouse, Partner, Child,
Other: _____

Household Income Sources (please list all that apply)

$_____Social Security (retirement)
$_____Unemployment

$_____Salary
$_____Public assistance

$_____Pension

$_____Short-Term Disability

$_____SSI
$_____Family/friends Support
$_____SSD (Disability)
$_____Other (please specify) _____

Household Expenses

$_____Mortgage/Rent

Is Mortgage or Lease in your name?
- □ Yes
- □ No–Explain_____

$_____Utilities
$_____Home/Renter Insurance

$_____Telephone
$_____Car Payment

$_____Health Insurance
$_____Medical Bills

$_____Auto Insurance
$_____Childcare

$_____Gas
$_____Groceries

$____Other
(specify)_____

Rank up to three areas of greatest need and give details.

- $ _____Transportation
- $ _____Mortgage/Rent
- $ _____Co-Pays/Premiums
- $ _____Utilities
- $ _____Medical Expenses
- $ _____Other-specify: _____

Consent Form

CONFIDENTIALITY CLAUSE
The GRACE Cancer Foundation considers this application, and its attached information, confidential. GRACE Cancer Foundation shall not use the confidential information other than for the purposes of its business with the applicant, and shall disclose it only to its officers, board members, or government agencies with a specific need to know. GRACE Cancer Foundation will not disclose, publish, or otherwise reveal any of the confidential information received from applicant to any other party whatsoever except with the specific prior written authorization of Applicant. By signing below, you give GRACE Cancer Foundation authorization to speak with the social work department and/or doctors to verify your situation.

_____
Initial

PUBLICITY AUTHORIZATION
I authorize GRACE Cancer Foundation to publicize information about myself or my family (including a medical condition, whether embodied in photographs, videotapes, recordings, and any other format (collectively, "Information"), for the purposes of promotion, publication, commercial advertising, or any other purpose whatsoever, now or at any time in the future. Participants understand and agree that GRACE Cancer Foundation may use any such Information: (1) in all manner and media whatsoever, whether now known or hereafter invented, including electronic and print media and the Internet; (2) with or without Participants' names; (3) without the payment of royalties or other compensation to anyone; and (4) without the need to notify them or to seek further approval before doing so.

_____
Initial

FACES OF GRACE
I hereby consent that my family would be willing to participate as a *Faces of GRACE* at a future GRACE Cancer Foundation event. This incudes, but is not limited to, participating in future events and the telling of my or my family's story.

_____
Initial

Grant Application Guidelines for Individuals/Families

Your medical facility will be contacted to verify the treatment of noted cancer patient as well as other organizations involved with your application. Please sign this form acknowledging your approval for the GRACE Cancer Foundation to verify this information.

Patient's Signature:_____

Date of Signature:_____

(Authorizes Release of Medical Information)
Description of each purpose for the use or release of the information [45 C.F.R 164.508 (c) (iv)]
This information will be used for the sole purpose of evaluation of the above patient for support service offered by the Grace Cancer Foundation. This HIPPA release is valid for a 180-day period from the patient's signature date shown above and only if signed by both the patient and Oncologist's Office.

SIGNATURE_____ ***DATE*** _____

I ATTEST BY WAY OF MY SIGNATURE THAT ANY FINANCIAL ASSISTANCE GRANTS WHICH MAY BE AWARDED WILL BE UTILIZED FOR THE EXPENSES INDICATED ABOVE

Requests can be mailed or delivered to:
GRACE Cancer Foundation
3310 West Capital Ave.
P.O. Box 5111
Grand Island, NE 68802
308-675-0889
sarah@gracefoundationgi.org