Welcome to Hope Chest GO!

Please read the following paragraph before completing the application:

1. This application should take you between 5-10 minutes to complete.
2. Grant applications are considered and processed pursuant to Hope Chest Go's Support Guidelines, which are available via this link.
3. Please have the first and last name, email address, and phone number of your Social Worker, Nurse Navigator, or Doctor. They will need to verify treatment before your grant application can be approved.
4. Grants are generally paid directly to the company owed. Please have the name, your account number, and the address of the company owed ready.
5. You will need to provide a copy of the bill(s) you wish to be paid with this application.

Patient Information

First Name: _____Last Name:_____

Phone number: _____

Are you a resident of Minnesota? (*Please circle)* YES NO Date of Birth:_____

Primary Address: _____

City: _____State:_____ Zip Code_____

County: _____Email Address: _____

Age range *(please circle your answer)*

18-24

25-34

35-44

45-54

55-64

65 and over

Gender*(Please circle your answer)*

Female

Male

Non-binary/third gender

Transgender

Cisgender

Agender

Genderqueer

A gender not listed

Prefer not to say

Race/Ethnicity *(Please circle your answer)*

Asian or Pacific Islander

Black or African American

Native American or Alaskan Native

White or Caucasian

Multiracial or Biracial

A race not listed

Prefer not to say

Are you of Hispanic, Latino, or Spanish origin? *(Please circle your answer)*

No, not of Hispanic, Latino, or Spanish Origin

Yes, Mexican, Mexican American, Chicano

Yes, Puerto Rican

Yes, Cuban

Prefer not to say

Have you received a grant from Hope Chest in the past 12 months? *(Please circle your answer)*

Yes No

Do you have metastatic or Stage 4 disease?*(Please circle your answer)*

Yes No Unsure

<u>Family Information</u>

How many dependents are living in the home?*(Please circle your answer)*

No Dependents

1 Dependent

2 Dependents

3 Dependents

4+ Dependents

Are you a single or dual-income household?*(Please circle your answer)*

Single-Income Dual-Income

What is your annual household income?*(Please circle your answer)*

$100,001+

$75,001-$100,000

$50,001-$75,000

$25,001-$50,000

Less than $25,000

Please indicate any/all treatment-related hardships: *(Please circle your answer)*

Travel 2+ hours for hospital/clinic visits

Frequent clinic visits (2+ times/week)

One or more inpatient hospitalizations in the past 90 days

Immediate family member(s), who are uninsured and unemployed, have (or had) a serious chronic illness in the past 12 months

None of the above apply

Employment and life: *(Please circle your answer)*

Patient earns primary income

Patient is on unpaid leave or unemployed

Patient is not currently receiving short-term disability

Other adults in home are on unpaid leave or unemployed

Patient does not have reliable transportation

Patient does not have stable housing

Patient does not have health insurance

None of the above apply

In order to help us understand your needs, please provide additional detail related to any boxes you checked in the Employment and Life section.

_____

_____

_____

_____

_____

Please provide any additional information such as date of onset, treatment status, family dynamics, and economic situation (family or personal) that would be helpful to evaluate the application:

_____

_____

_____

_____

Hospital/Clinic Information

Primary hospital:_____

Hospital City:_____Hospital Zip Code:_____

Name of Oncology/Radiation care facility:_____

Name of Social Worker/Healthcare Provider:_____

Phone Number of Social Worker/Healthcare Provider:_____

Financial Support Request

Types of expense or bill needing payment:*(Check all that apply)*

Mortgage Payment

Rent Payment

Utilities

Transportation

Transportation (Gas Card)

Transportation (Uber Gift Card)

Childcare

Grocery Gift

Other

Check Payable To (Name of Creditor):_____

Account Number with Creditor:_____

Creditor Address:_____

City:_____ State:_____Zip Code:_____

Creditor Phone Number:_____

Requested Amount:_____Due Date:_____

Additional comments on the amount/type of request:_____

_____

_____

Please Include a copy of bill with application if applicable.

How did you hear about Hope Chest for Breast Cancer Foundation?_____

Let's Stay in Touch

- ☐ I would like to share my story, my breast cancer journey and how Hope Chest for Breast Cancer Foundation has helped me. Please contact me.
- ☐ I would like to keep up to date on Hope Chest for Breast Cancer Foundation's work in the community. Please include me on your newsletter and mailing distribution.
- ☐ I authorize the verifier (healthcare provider, social worker, etc.) provided on this form to release information (including diagnosis, treatment status and other pertinent information related to grant request) to Hope Chest for Breast Cancer Foundation as necessary) to determine eligibility and processing of this grant request.
- ☐ I understand that my personal information will not be published or shared with the public or a third party, except as provider herein, without my consent. Personal information is defined as home address, phone number, email address, medical information, and creditor information.

Applicant Signature:_____

Date: _____