

Sue's Gift Financial Assistance Program

The Sue's Gift Financial Assistance Program is dedicated to supporting women in Colorado with gynecologic cancers by helping with medical and daily living expenses during and immediately after cancer treatment.

Grants may be given to qualified applicants in the amount of \$1,000 per year for such things as:**

- Medical expenses
- Prescriptions
- Rent or mortgage payment
- Utility bills
- Car payment
- Car insurance
- Health insurance deductibles
- Psychiatrist visits

The program pays bills and does not award funds directly to individuals. **Yearly assistance limit is \$1,000 per person per calendar year with a lifetime assistance limit of \$2,000. Submission of an application is not a guarantee of assistance.

To Qualify for Assistance:

Gynecologic cancer patients who meet the following residency, medical and financial qualifications may submit an application for consideration.

Residency: (Proof of Colorado residency is required with the application.)

1. A resident of the southern half of the state of Colorado or
2. Colorado resident state-wide if participating in the Woman to Woman peer support program

(Note: A Woman to Woman (W2W) grant has allowed us to expand our financial assistance statewide. To participate in the W2W program and talk with a survivor with your diagnosis, complete an online application at www.suesgift.org.)

Medical:

1. Diagnosis of a gynecologic cancer
2. Currently receiving treatment (e.g. chemotherapy, radiation therapy, surgery, PARP-inhibitor) or completed treatment for a gynecologic cancer within the last three months

Financial:

1. Your monthly household expenses must be more than your monthly household income (defined as income received from patient and their domestic partner, regardless of gender), and your total household income must be less than or equal to 300% of the HHS Federal Poverty Level. In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your county. (www.huduser.org)
2. Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.

You may be asked to provide additional paperwork in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, Sue's Gift has the right to withdraw your application, stop all assistance and take steps to recover previous awards.

Follow these steps below to apply for assistance.

Step 1: Fill out the Sue's Gift Application pages 1 – 4.

Step 2: Have your oncologist's office complete the Medical Verification form on page 5 which can be returned with your completed application or the office may send it in separately.

Step 3: Make a copy of your current Colorado Driver's License, Colorado-issued I.D. **or** other proof of residency with an address matching your application (e.g. utility bill, etc.), and include with your application.

Step 4: Mail your completed application** and all required attachments to:

Sherry Martin, LCSW
Sue's Gift
525 N. Cascade Ave., Suite 213
Colorado Springs CO 80903

**For quicker processing, email the application to sherry@suesgift.org or fax it to 719-264-1094. Please be sure to provide all the information requested here. An incomplete application will delay our ability to provide you with assistance.

Once we receive your application, the Sue's Gift Task Force committee will review it and send you an Agreement or Decline letter by mail or email. If your application has been accepted, you will be contacted to determine how to proceed with bill payment.

This is also a time to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact: Sherry Martin, Patient Services Director, at 719-422-9964 or sherry@suesgift.org.



SUE'S GIFT FINANCIAL ASSISTANCE PROGRAM

Personal Information

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

County _____ Date of Birth _____ Email address _____

Phone: Home _____ Mobile _____ Work _____

Best way to reach you: (circle one) Home Phone Cell Phone Work Phone Email

Best time to reach you: (circle one) Morning Afternoon Evening Best hours: _____

Marital Status: (circle one) Single Married Partnered Separated Divorced Widowed

Additional Contact Person:

Name _____ Relationship _____ Phone _____

Do you have health insurance? ___Yes ___No If yes, please indicate type of insurance:

(check all that apply) ___Private insurance ___Medicare ___Medicaid ___VA ___Other

If private insurance, please name insurance company _____

Comments: _____

Are you currently working? ___Yes ___No If yes, how many hours per week? _____

Were you working before your cancer diagnosis? ___Yes ___No

Total # in household _____ # of wage-earners in home _____ # of dependents _____

Who referred you? _____ Referring person's phone _____

Referring person's email _____

Have you received Sue's Gift before? ___Yes ___No If yes, what year? _____

Are you participating in the Woman to Woman peer support program? ___Yes ___No



Name: _____

Sue's Gift Application / Income Information

(Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.)

TOTAL CURRENT MONTHLY INCOME: \$ _____

Please list details below:

Wages

Your wages after payroll taxes \$ _____
Spouse or partner's wages after payroll taxes \$ _____
Other income from wages or self-employment \$ _____

Income from Benefits & Insurance

Employer disability insurance \$ _____
Unemployment insurance \$ _____
Retirement / Pension \$ _____
401K / IRA income \$ _____
Social Security \$ _____
SSI / SSDI \$ _____
Other benefits/Insurance \$ _____
Income from assistance alimony / Child support received \$ _____
Low-Income Energy Assistance Program (LEAP) \$ _____
Food Stamps (SNAP) \$ _____
Temporary Aid to Needy Families (TANF) \$ _____
Aid to the Needy and Disabled (AND) \$ _____
Section 8 from HUD (housing supplement) \$ _____
Help from family members \$ _____
Help from religious / faith community \$ _____
Help from friends \$ _____
Help from other nonprofit organizations \$ _____
Other Assistance \$ _____

Assets

Cash / Checking Value: _____
Savings Value: _____
Life insurance value: _____
Investments value: _____
Real estate value: _____

(Not the house you live in)

Monthly Income From

\$ _____
\$ _____
\$ _____
\$ _____
\$ _____



Name: _____

Sue's Gift Application / Expenses Information

TOTAL CURRENT MONTHLY EXPENSES: \$ _____

Please list details below:

Household Expenses

Rent \$ _____
Mortgage \$ _____
Energy bill \$ _____
Water bill \$ _____
TV / Internet / Cable / Satellite \$ _____
Telephone / Cell (including long distance) \$ _____
Food \$ _____

Dependent Expenses

Child care \$ _____
Child support paid \$ _____
Elder care \$ _____

Transportation Expenses

Car payment \$ _____
Gasoline \$ _____
Car insurance \$ _____
Parking / Public transportation \$ _____

Medical Expenses

Health insurance premiums \$ _____
Medical costs (after Insurance) \$ _____
Medication costs (after insurance) \$ _____

Loan Expenses

Loan payments \$ _____
Credit card payments \$ _____

Other Expenses

Other: _____ \$ _____
Other: _____ \$ _____
Other: _____ \$ _____

Are you currently seeking any assistance or debt relief for outstanding expense payments? Please explain:



Name: _____

Sue's Gift Application / Gynecologic Cancer History

Date Diagnosed _____ Type of Gynecologic Cancer _____ Stage _____

Have you experienced a recurrence? _____ Have you seen a Gynecologic Oncologist? _____

Have you participated in a clinical trial? _____ Treatment Facility _____

Surgeon _____ Oncologist _____

Social Worker _____ Nurse / Navigator _____

Please check your reason for applying for financial assistance:

- _____ To help pay an annual health insurance deductible
- _____ To help pay for a prescription
- _____ To help pay for a psychiatrist
- _____ To help pay for other medical expenses
- _____ To help pay housing expenses (rent or mortgage)
- _____ To help pay for utilities
- _____ To help pay for car payments

Read and check the lines to verify the following information:

- _____ I have read Page 1 and understand how and who Sue's Gift helps with financial assistance.
- _____ I live in Southern Colorado.
- _____ I am participating in the Woman to Woman peer support program.
- _____ I have enclosed proof of residency.
- _____ I am currently undergoing chemotherapy or other oncologist-directed treatment for gyn cancer.
- _____ I am currently within three months of gynecologic cancer-related surgery, chemotherapy, or oncologist-directed treatment.
- _____ I have signed the bottom of this page, which serves as a medical release giving Sue's Gift permission to obtain the necessary medical information to process my application.
- _____ I understand that Sue's Gift will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview.
- _____ I understand that the Sue's Gift provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release Sue's Gift from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize Sue's Gift to release any information including my name, address, and type of assistance provided to any other social service agency at Sue's Gifts's discretion. I also authorize the release of any medical information and documentation required by Sue's Gift for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.

Applicant's Signature _____ Print Name _____ Date: _____



Healthcare

Provider: Please complete and mail, email, or fax to Sue's Gift. Thank you for your assistance.

Mail: Sherry Martin, LCSW
Sue's Gift
525 N. Cascade, Suite 213
Colorado Springs, CO 80903

Email: sherry@suesgift.org

Fax: 719-264-1094

Sue's Gift Medical Verification

Patient name _____ Confirmed diagnosis _____

Date of initial diagnosis _____ Stage _____ Cell type _____ Grade _____

Patient is currently seeing a Gynecologic Oncologist: ___Yes___No Name _____

Patient is currently seeing a Medical Oncologist: ___Yes___No Name _____

Patient is currently being treated for a recurrence: ___Yes___No Recurrence date _____

Patient is currently undergoing chemotherapy: ___Yes___No

Chemotherapy start date _____ Anticipated end date _____

Drug _____ Drug _____

Drug _____ Drug _____

Patient has undergone surgery: ___Yes___No Most recent surgery date _____

Patient has a planned surgery: ___Yes___No Planned surgery date _____

Surgical procedure: _____

Patient is being admitted to a clinical drug trial: ___Yes___No

Clinical trial start date _____ Anticipated end date _____

Other planned treatment(s) or important medical information about this patient's gynecologic cancer treatment _____

Referring licensed professional completing this form: (MD, DO, PA, NP, RN, RN or LCSW)

Name & Credentials _____ Hospital/Clinic _____

Address _____ City _____

State _____ Zip _____ Phone () _____ Email _____

My signature below affirms the diagnosis and treatment information as described on this page.

Referring professional signature _____ Date: _____