FINANCIAL ASSISTANCE PACKET

www.carepartnersmn.org
P.O. Box 217
Eveleth, Minnesota 55734

Phone: 218.404.1411
Email: coordinator@carepartnersmn.org

Dear Applicant,

Thank you for contacting Care Partners. Our Financial Assistance program is designed to help individuals and families who reside on the Iron Range facing cancer or a life-limiting illness.

Care Partners requires that an applicant complete our application for financial assistance. To better assist you, please fill out the application carefully and completely.

Here is an overview of Care Partner's procedures. Please contact us if you have any questions or concerns.

Care Partner's Procedures:

1. **FORM A.** (Patient Information) Needs to be completed by the patient, **including a signature (guardian signature required for minor).**

2. **FORM B.** (Medical Information) Needs to be completed. Medical records **do not** need to be sent.

3. **FORM C.** (Release Form) Needs to be completed by the patient, **including a signature.**

4. Please mail all completed paperwork to the address listed below. Upon receipt of the paperwork, Care Partners will call the patient to inform them of the qualifying grant details.

5. **FORMS A, B AND C of the application MUST be completed** in order to be processed. **Incomplete applications will be returned** for completion and **will not** be reviewed until a completed application is submitted.

GRANT GUIDELINES AND CRITERIA FOR FUNDING

Service Area

- Patient must reside on the Iron Range in Northeast Minnesota.

Grant Requirements

- Patient must have a cancer diagnosis or a life-limiting illness.
- All Forms (A, B and C) must be completed and signed where indicated.

Eligible Requests

- Care Partners **will consider** all requests for financial assistance.

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FORM A (please print)

PATIENT INFORMATION FORM

Patient Information: (use address label if available)

First Name: _____ Last Name: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Phone: (____) ____ - _____ Email: _____

Cell: (____) ____ - _____ Work: (____) ____ - _____

Alternative Contact (if different than above):

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Relationship to patient: _____

Phone: (____) ____ - _____ Email: _____

Cell: (____) ____ - _____ Work: (____) ____ - _____

Please list the people in your household who will be helping you:

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please check areas you would like help with:

_____ Long Distance Travel (gas, food, lodging) _____ Medical Bills _____ Daily Living Expenses

_____ Local Travel (gas) _____ Medication/Supplies _____ Complimentary Therapy

_____ Other: Explain

_____

_____

_____

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FORM B (please print)

MEDICAL INFORMATION FORM

Date: _____

Patient Information:

First Name: _____ Last Name: _____

Birth date: ____/____/____ Gender: M ____ F ____

Diagnosis: (type/form) _____ Stage: _____ Date of Diagnosis: _____

Medical Facility: _____

Current Treatment: (CHECK ALL THAT APPLY)

____ Chemotherapy Date of last Treatment: _____ ____ Hospice Date entered: _____

Medical facility _____ How often _____

____ Radiation Date of last Treatment: _____ ____ Palliative Care Date entered: _____

Medical facility _____ How often _____

____ Bone Marrow Transplant Date of transplant: _____

Non-Cancer Life-limiting Illness:

Diagnosis/Illness: _____

Current Treatment: _____

Clinic Information:

Clinic: _____ Oncologist: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (____) ____ - _____

Social Worker/Health Care Professional Information:

Name: _____ Phone: (____) ____ - _____

Clinic/Organization: _____

Address: _____

City: _____ State: _____ Zip: _____ Fax: (____) ____ - _____

Email: _____

**Please attach additional clinic information if necessary.

FORM C (please print)
RELEASE FORM

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Care Partners. I hereby give my permission that this application and all information provided can be sent to Care Partners and discussed with my health care professional if necessary. All information reviewed is confidential. I understand all help is based on funding availability.

Patient Signature: _____ Date: _____

(Gurdian signature required for minor) _____

Print Name: _____

Please take some time to answer the questions below.

I would like to be on Care Partners mailing list: _____ Yes _____ No

How did you hear about Care Partners?

____ Social Worker - Name: _____

____ Oncologist - Name: _____ Facility: _____

____ Nurse - Name: _____ Facility: _____

____ Friend - Name: _____

____ Internet - Source: _____

____ Patient Navigator - Name: _____ Facility: _____

____ Brochure

____ Other: _____

Please provide additional comments regarding your situation that might be helpful when reviewing your application.

_____

_____

_____

_____

_____

_____

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