FINANCIAL ASSISTANCE APPLICATION

Moms on the Run provides financial assistance for everyday living expenses including, but not limited to, rent/mortgage, car payments, insurance, food, etc. We would like to help relieve your financial stress while on your journey to wellness.

CRITERIA FOR ACCEPTANCE:

1. ***Northern Nevada Resident.*** Residency is determined by where a person primarily resides. Persons living in the Northern Nevada area are eligible for assistance.
2. ***Active breast or gynecological cancer at time of application.*** Medical records will be reviewed to verify the diagnosis of breast cancer.
3. ***Financial need.*** Each person's financial situation is reviewed on an individual basis.

Due to limited funds, we are not able to help on a permanent basis; only for a specified period.

APPLICANT INFORMATION: Date: ____________________________________

Name: ____

Address: _______________________________City: __________ State: NV Zip: _________

Telephone: ____________________________________

E-Mail Address: ____

☐ Only send emails regarding assistance. ☐ Send informational emails. ☐ Sign me up for both!

Birth Date: __________________ Age: ________ Social Security #: _____________________

Currently Employed: Y or N Full Time or Part Time Last Date Able to Work: ____________

Occupation: ______________________________ Employer: ___________________________

Married: Y or N Spouse's Name: _______________________________________

Spouse's Occupation: ________________________ Employer: ___________________________

Children & Ages: ____

Date Diagnosed: ___________ Type of Cancer: ____________ Hospital: _________________

APPLICANT INFORMATION CONTINUED:

Oncologist/Surgeon: ___________________ Nurse Navigator/Social Worker: _______________

Agencies applied to & received assistance from: ____

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Are you currently sponsored in the St. Mary's Cancer Rehabilitation Program? ☐ Yes ☐ No

Do you have insurance? ___________ Insurance Provider: ________________________________

Total Monthly Income of Combined Household: $________________________

Monthly Expenses:

Rent/Mortgage: $________________ Food: $________________ Utilities: $________________

Car Expenses: $ ________________ Other: ____

FINANCIAL RESOURCES STATEMENT:
Please List All Sources of Family Income.

Employment Earnings: $__________________ Unemployment Benefits: $__________________

Social Security (SSI or SSD): $___________________ Veterans' Benefits: $___________________

Welfare/Public Assistance/Food Stamps: $__________________

Retirement or Pension: $___________________ Child Support/Alimony: $___________________

Interest/Dividends: $__________________ Other: $________________________

Checking Acct: $___________ Savings Acct: $___________ Retirement/401K Acct: $ __________

I hereby declare the above to be a true and actual statement of my finances.

Signature: ____ *Date:* ____________________

Please write detailed information about your breast/gynecological diagnosis:

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Important* – What will your treatment be? Start and end dates of all?

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What are your current financial needs? Please specify the living expenses for which you are seeking assistance.

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WAIVER AND RELEASE OF LIABILITY

I have requested financial aid from Moms on the Run, a non-profit charitable organization which assists women in northern Nevada during treatment of breast and gynecologic cancers. I understand that the granting of financial assistance by Moms on the Run is entirely discretionary at all times and that Moms on the Run may deny or terminate such aid for any reason at any time. I also acknowledge that I have the right to ask Moms on the Run any questions that I have or many have concerning available benefits, eligibility or this waiver.

I hereby agree to take all the actions that are or may be required of me pursuant to the application process, including, but not limited to providing all the necessary information to determine eligibility for benefits, which may be accomplished by executing the appropriate authorization and consent for the release of information to Moms on the Run.

On the basis of the forgoing, I, on behalf of myself and my heirs, successors and assigns, hereby waive and release Moms on the Run, including its officers, directors, employees and volunteers, from any and all claims, damages and/or costs of whatever kind, whether legal or equitable and whether based on theories of contract, tort, or otherwise, that I have now or in the future that may arise out of or relate in any way to my application for assistance from Moms on the Run and/or any grant, denial, increase or termination of assistance made as a result of my application or the process of review.

I have carefully read the forgoing release in its entirety and know and understand the contents thereof and sign the same as my own free act.

DATED this __________ day of ________________________________, 20 ________.

Signature: ____

Social Security No.: ____

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION TO MOMS ON THE RUN

To: ____

You are hereby authorized and directed to disclose, deliver or furnish to Moms on the Run, a non-profit charitable organization, 5995 S. Virginia St., Reno, Nevada 89502, or any representative of Moms on the Run, pursuant to HIPAA Privacy Rule (Section 164.508), copies of any and all medical and/or hospital records relating to the past, present or future physical condition of

____.

This release is also intended to authorize the disclosure of financial, employment and/or other personal information necessary to determine eligibility for benefits for which I have applied to Moms on the Run.

The release of information and/or disclosure authorized by way of this release may be made via telephone or written correspondence.

This release is made for the sole purpose of establishing eligibility for benefits for which I have applied to Moms on the Run and is not a waiver of my privilege as to the content of those records for any other purpose. By signing this authorization, I understand that I may revoke this authorization at any time in writing. My written revocation will become effective upon receipt, but will not apply to any medical, financial, employment and/or other information and records released prior to that date or to the extent that your office/facility has taken action in reliance upon this authorization.

This authorization will expire six (6) months from the date of signature.

It is agreed that a photocopy of this authorization shall have the same force and effect as the original.

DATED this __________ day of ________________________________, 20 ________.

Signature: ____