



- ✓ **Emergency Financial Assistance Grant**
- ✓ **Financial Cancer Care Program**
- ✓ **Adult & Family Programs**

Application Requirements

- Patient completes **all sections** and signs the application.
- A member of your oncology care team completes and signs the Medical Information Form.



THREE WAYS TO COMPLETE APPLICATION

1. Complete printed copy and return in-person or via email to:
Angel Foundation
1155 Centre Pointe Dr., Ste. 7
Mendota Heights, MN 55120
or you can email it to grants@mnangel.org
2. To apply online, please visit mnangel.org
3. Scan this QR code



I am applying for:

Emergency Financial Assistance (EFA) Grant

EFA supports adult cancer patients by relieving some of their non-medical living expenses. To be eligible, the patient must:

- Be 18 years of age or older.
- Be in active treatment** for cancer.
- Meet financial guidelines set by Angel FoundationTM.
- Be a Minnesota or Wisconsin resident living or receiving cancer treatment in the following fifteen Minnesota or Wisconsin Counties: Anoka, Carver, Chisago, Dakota, Douglas (WI), Hennepin, Isanti, Olmsted, Ramsey, Scott, Sherburne, St. Croix (WI), St. Louis, Washington, and Wright.

**Treatment includes one or more of the following:

- Chemotherapy
- Clinical trials
- Hormone therapy
- Hospice
- Immunotherapy
- Palliative care
- Radiation
- Transplant
- Surgery
- Other treatment per healthcare provider

Financial Cancer Care (FCC) Program

Designed to help patients impacted by cancer manage finances through virtual workshops and one-on-one planning with a Certified Financial Planner® (CFP®).

For patient or family member to register for the FCC Workshop:

- 18 years of age or older.
- Live in or receive cancer treatment in one of the fourteen counties listed above.
- Have received treatment** for cancer within the last two years.

To meet one-on-one with a CFP®:

- Meet all FCC Workshop criteria.
- Be financially independent.
- Not currently be working with a Financial Planner.

Adult & Family Programs (AFP)

Provide education and social activities designed to help families and individuals emotionally and practically after a loved one is diagnosed with cancer.

All families impacted by cancer in our service area can participate.

Angel PacksTM

Are designed to support children when a loved one is diagnosed with cancer, Angel PacksTM include engaging activities, coping tools, and a parent guidebook to facilitate age-appropriate conversations. Each pack helps families navigate the challenges of cancer while providing reassurance and valuable support strategies.

- **Circle your desired pack type(s):** Child: 4-8, Preteen: 9-12, Teen: 13-18.

Patient Information *Required



Who is filling out the application?*

- ☐ I am the patient, applying for myself.
- ☐ I am an oncology healthcare professional assisting the patient.
- ☐ I am assisting the patient and will indicate my relationship below.

Your name: _____ Relationship to patient: _____

First Name* _____ Middle Initial _____ Last Name* _____

Preferred Name _____ Birthdate* (MM/DD/YYYY) ____/____/____

Street Address* _____ Apt # _____

City* _____ State* _____ Zip* _____ County* _____

Phone/Mobile* _____ Email* _____

Please list others we can discuss your application with besides your oncology team:

Would you like Angel Foundation™ to contact you regarding other community resources?

- ☐ Yes
- ☐ No

If yes, how would you like to be contacted?

How would you like to be contacted about your application?*

- ☐ Email
- ☐ Letter

May we leave a message on your phone?*

- ☐ Yes
- ☐ No

Do you need language translation?

- ☐ Yes
- ☐ No

If yes, what language? _____

Demographic Information

Your responses to the following questions enable Angel Foundation™ to better serve communities equitably. All responses are kept private and secured and will not be used for discriminatory purposes.

What gender do you identify as?*

- ☐ Female
☐ Male
☐ Non-Binary
☐ Two-Spirit
☐ Prefer not to answer
☐ Other (Please Specify)

Have you participated in active duty in the military?*

- ☐ Yes
☐ No
☐ Prefer not to answer

What race, ethnicity, or tribal affiliation do you identify with?*

- ☐ American Indian or Native Alaskan
☐ Asian, Native Hawaiian, or Pacific Islander
☐ Black or African American
☐ Hispanic, Latina/o/x Spanish origin
☐ Middle Eastern or North African
☐ Non-Hispanic White
☐ Two or More Races
☐ Prefer not to answer
☐ Tribal Affiliation (Please specify)

☐ Other (Please specify)

Marital Status*

- ☐ Divorced
☐ Married
☐ Partnership
☐ Separated
☐ Single
☐ Widowed
☐ Prefer not to answer

Medical Information

Cancer Diagnosis:* _____

Cancer Stage*

- ☐ I ☐ III ☐ O ☐ Remission
☐ II ☐ IV ☐ None Specified ☐ Recurrent

Type of Treatment:* _____

Clinic/Hospital Name:* _____

City:* _____

Oncologist Name:* _____

Household Information

Please list the total number of people living in your household, including yourself:* _____

Do you have school-aged children in your household (ages 4-18)?*

- ☐ Yes ☐ No

If yes, please list their names and ages:

Child 1 Age, Name:

Child 2 Age, Name:

Child 3 Age, Name:

Child 4 Age, Name:

If you have more than four children, check this box:

What is your housing situation?*

- ☐ Stable ☐ Unstable ☐ Prefer not to answer

Medical Insurance Provider: _____

Total Net Monthly Household Income (after taxes):* _____

Additional Information

How did you hear about Angel Foundation™?*

- ☐ Community Health Worker ☐ Friend/Relative
☐ Community Organization ☐ Internet
(please specify) ☐ Nurse
☐ Doctor ☐ Patient Counselor/Navigator
☐ Social Worker

May we add you to our mailing list?*

- ☐ Yes ☐ No

Will you be willing to share your story with our community?*

- ☐ Yes ☐ No This is not required to receive assistance. If you choose yes, someone from Angel Foundation™ may contact you.

Please tell us anything else you would like us to know:

☐ Please check here to be contacted about your situation.



Patient Release

- ☐ I declare the information on this application is true and correct to the best of my knowledge. I understand that each application is reviewed on a case-by-case basis, and the final decision will be made by Angel Foundation™. I hereby give my permission that this application and all information offered can be provided to Angel Foundation™ and discussed with my healthcare professional. I understand that all information reviewed is confidential.

Signature* _____ Date of Signature* ____/____/____