The John Estrella Foundation for Cancer Research
providing hope through research

Helping Hand Grant Application

Name of applicant: ____

Who is completing this application?

☐ I am a kidney cancer patient

☐ I am a family member/friend completing this application on behalf of a patient

Mailing address:____

Phone number:____

Email: ____

Date of Birth:______/______/_______

Gender at birth: ☐ Male ☐ Female

Are you a U.S. Veteran? ☐ Yes ☐ No

Ethnicity: ☐ **American Indian** ☐ **Asian or Pacific Islander** ☐ **Black or African American** ☐ **Caucasian** ☐ **Hispanic** ☐ **Latino** ☐ **Multiracial** ☐ **Other**

How did you learn about the John Estrella Foundation for Cancer Research Patient Grant Program?

☐ Website:_______________________________________

☐ Physician

☐ Social Worker

☐ Social Media (e.g. Facebook)

☐ Support Group

☐ Other:__________________________

Have you received a Helping Hand Grant in the last 12 months? **Yes** ☐ **No** ☐

When were you (or your relative with kidney cancer) diagnosed with kidney cancer? _____________

Are you currently undergoing active treatment for kidney cancer? *Active treatment is defined as the period after a positive diagnosis of kidney cancer has been made, and during which therapies are being administered, including surgical procedures to remove the cancer, chemotherapy or radiation*

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☐ **Yes** ☐ **No**

Diagnosis Status?

☐ New diagnosis (< 6 months)

☐ Existing diagnosis (7mo – 2yr)

☐ Relapse diagnosis (2+ yrs)

☐ New diagnosis in advanced stage and/or aggressive disease

Family Information

How many adults live in your household? _________________ Children? _______________________

Marital Status: ________________________ Annual Household Income: _______________________

Treatment Related Hardships (check all that apply):

- Travel 2+ hours for hospital/clinic visits
- Seeking temporary housing to be closer to hospital
- Frequent clinic visits (2+ times/week)
- Hospitalized 15 of last 90 days
- Hospitalized 30 of last 90 days
- Family has lost additional member(s) with serious chronic illness
- Prescribed therapy out of state
- End of life / hospice / bereavement

Employment and Life (check all that apply):

- Patient is on unpaid leave or unemployed
- Other adults in home are on unpaid leave or unemployed
- Primary household earner is self-employed
- No reliable transportation
- No stable housing

If you checked any of the boxes above (Employment and Life), please provide more details below:

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:

My Request

How much are you requesting? __$________________ The maximum amount that will be awarded regardless of the request is $1,000 even if the financial need is greater. Applicant is responsible for remainder. For example, if a new handicap ramp costs $1,500, applicant may receive up to $1,000 to supplement the cost of this expense.

What are you requesting funds for? Please describe how this request pertains to a hardship resulting from your (or your loved one's) diagnosis of kidney cancer. Be as specific as possible. Examples of qualifying requests include costs of transportation, home care, childcare, food delivery, supportive equipment (e.g. wheelchairs, stair lift, ramp, etc.), durable medical equipment, palliative care, and/or genetic counseling. In addition, please articulate why this is a financial burden (e.g. lost wages, cost of expenses exceed income, etc.) Please note that funds cannot be requested for medical co-payments, deductibles, prescriptions, hospital, or physician charges. More information about help with medical expenses can be found at https://www.cancercare.org/publications/62-sources_of_financial_assistance

Authorization

☐ I authorize the healthcare provider listed on the **Diagnosis Verification Form** below to release information (including diagnosis, treatment status and other pertinent information related to this grant request) to the John Estrella Foundation for Cancer Research, Inc. as necessary to determine eligibility and processing of this grant request.

☐ If awarded and accepted, I give consent to the John Estrella Foundation for Cancer Research, inc to disclose to the general public via television, radio stations, newspapers, websites, magazines, newsletters, social media, as well as in educational and fundraising opportunities my family's story (including diagnosis and general story provided in grant application) and any photo provided by me to the John Estrella Foundation for Cancer Research, Inc.

☐ I understand that submission of a grant application does not guarantee my request will be granted.

☐ I attest that the information contained in this application is true to the best of my knowledge.

Applicant Signature: ____

Date: ______________________

Helping Hands Reference Letter

Please provide this to your reference to complete and mail to the John Estrella Foundation for Cancer Research

I am applying for a Helping Hands Grant from the John Estrella Foundation for Cancer Research, Inc. to help with expenses related to kidney cancer. My application requires a reference from a non-family member (examples: community leaders, friends, pastoral care, etc.) to speak to my need and credibility. Please complete the information below and send it to the foundation.

Applicant's name: ________________________________

Amount requested: _$_____________

Funds will be used for: ____

Name of reference: _________________________________

Address of reference: _____________________________________

Phone number of reference: ________________________

Reference should mail completed letter to the John Estrella Foundation, 3 Seward Avenue, Beverly, MA 01915 – **letter must be postmarked no later than June 6, 2020**. Please include how you know the applicant, your perception of the proposed need, and anything else you think may be pertinent for the Grant Review Committee to know. **Failure to return this letter by the deadline may disqualify the applicant from this award.**

Diagnosis Verification Form

Please provide to your oncologist to complete

This Diagnosis Verification Form must be completed and signed by the treating physician

The information requested below is necessary to complete the patient's application to the grant award. Please send completed form to: John Estrella Foundation, 3 Seward Avenue, Beverly, MA 01915

Applicant Patient Name: ___________________________________ Patient date of birth: ____/_____/____

Treating Physician Information

Physician Name: ____

Facility/Practice Name: ____

Street Address:

____

City: ________________________________ State: _____________ Zip Code: _________________________

Telephone: ________________________________ Ext: _____________ Fax: _________________________

Tax ID Number: ____

NPI Number: ____

Physician Email: ____

Office Contact Name: ____

Office Contact Email: ____

Diagnosis and Treatment Information Patient's Primary Diagnosis: __________________________________

Date of Diagnosis: ____

Began Treatment or will begin treatment on: ____

Ended Treatment or will end treatment on: ____

Physician Attestation

I attest that I have confirmed the patient's diagnosis and that all information supplied is complete, accurate, and supported in the patient's medical records. I understand this information is for the sole use of the John Estrella Foundation for Cancer Research, its representatives, and/or agents assigned to assess the patient's eligibility for participation in the Program. I understand that application to and/or approval for the John Estrella Foundation for Cancer Research does not guarantee financial assistance.

Physician Signature: ____ Date: ________________________

Contact The John Estrella Foundation for Cancer Research, Inc. with questions.