Village Keeper Program Assistance Application Packet 2017-2018

"The other side of cancer care"

1604 East 15th Street Jacksonville, Florida 32206

Dear Social Worker or Health Care Professional,

The SisterHermana Foundation requires that an applicant work with a social worker or health care professional to help them complete our application for monetary or in-kind assistance. The health care professional or social worker will also serve as our main contact if questions arise regarding the patient's application.

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

SisterHermana Foundation Procedures:

1. The Medical Information Form and top portion of the Patient Information form needs to be completed by a social worker or health care professional. An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to verify the patient has cancer and is currently undergoing treatment by signing the Medical Information Form. Medical records do not need to be sent.

2. The Patient Information Form and Release Form need to be completed by the patient, including the patient's signature.

3. Please mail the completed paperwork to the address on the cover page. Once the application has been processed, SisterHermana Foundation will contact the patient, social worker or health care professional via mail or email to inform them of the acceptance into the Village Keeper Program.

4. All three pages 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.

GENERAL GUIDELINES AND CRITERIA FOR ASSISTANCE

General Requirements

- Patient must be living in, or treated in, Duval County, Clay County, and Nassau County.
- Patient must be 18 years or older.
- Patient must have a cancer diagnosis and be in active treatment.
  - Active treatment includes chemotherapy, radiation, bone marrow transplant, hospice or palliative care and surgery when the recovery period is in excess of 6 weeks.
  - Active treatment does not include hormone therapy.
- Patient must meet financial guidelines set by SisterHermana Foundation.

Application Requirements

- The Medical Information Form and top portion of the Patient Information Form must be completed by a social worker or health care professional.
- An Oncologist, Registered Oncology Nurse or licensed medical Social Worker needs to sign the Medical Information Form to confirm the cancer diagnosis.
- The Release Form must be signed by the patient.

Eligible Requests

- **Based on availability** SisterHermana Foundation approves requests for basic living expenses such as rent or mortgage, food, gas and utilities.
- **Based on availability** if approved for a housing and utility assistance, copies of all eligible bills to be paid must be submitted to SisterHermana Foundation.
- If requesting assistance with rent, a copy of the first page of the lease or a letter from the landlord is required.
- **Based on availability** SisterHermana Foundation provides a $500 grants to high school seniors to pay fees associated with prom, yearbook, and grad night. Checks are made payable to the school or retail vender.

Ineligible Requests

- SisterHermana Foundation does not approve requests for payment of medical bills, prescriptions, or alternative medicines/therapies.
- SisterHermana Foundation does not approve requests for payment on bills other than rent, mortgage, food, gas or utilities.

Administration

- Checks will be made payable to vendors and returned to the patient to submit.
- Checks will not be made payable directly to patients.
- If approved, assistance expires after 90 days.

MEDICAL INFORMATION FORM
TO BE FILLED OUT BY HEALTH CARE PROFESSIONAL

Patient Information: Date: __________________

First Name: ___________________________ Last Name: _______________________________________

Date of Birth: ____________________ Gender: M ___ F ____ Veteran: Yes ________ No __________

Racial/Ethnic Identity: __________________ Marital Status: _____________________________________

(I.e. single, married, divorced, widowed)

Diagnosis:________________________ Stage: _________ Date of Diagnosis: _______________________

Current Treatment (Check all that apply)

______ Chemotherapy Date of Last Treatment: ____________________

______ Radiation Date of Last Treatment: ____________________

______ Bone Marrow Transplant Date of Last Treatment: ____________________

______ Surgery Date of Last Surgery: ______________________

______ Palliative Care Date Entered: _____________________________

______ Hospice Date Entered: _____________________________

TO BE SIGNED BY TREATING ONCOLOGIST, REGISTERED ONCOLOGY NURSE
OR LICENSED MEDICAL SOCIAL WORKER
I attest the patient has cancer and is currently being treated as stated above

X____

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: ____

*Information regarding the qualifying amount for this patient will be sent to you via email

PATIENT INFORMATION FORM

Social Worker/Health Care Professional: Please inform us why the patient is in need of Emergency Financial Assistance (REQUIRED):

____
____
____

Patient Information

First Name:____________________Last Name:__________________________________

Address:___________________________________City: __________________________

State:_______Zip:________County:_________________Phone:_____________________

Email:____

Is okay to leave a message on your phone? Yes No

Inform me regarding my application via _ _Email or ___ Mail

Responsible Party (If different than above)

First Name:____________________Last Name:_________________________________

Address:__________________________________City: __________________________

State:_______Zip:________County:_________________Phone:____________________

Email:_____________________________Relationship to patient:___________________

Please list the people in your household

Name	Date of Birth	Relationship

Financial Information

Total Monthly Household Income (After Taxes):_______________________________

Estimated Household Assets (Do Not Include Retirement Accounts):

Checking:_______________Savings/CD:_______________Stocks:_______________

Savings Bonds:_________Money Market______________Other:________________

Total Estimated Household Assets:____

PATIENT 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 SisterHermana Foundation. I hereby give my permission that this application and all information provided can be sent to SisterHermana Foundation and discussed with my health care professional. All information reviewed is confidential.

Patient Signature:______________________________________Date:_____________

Print Name:____

Please take some time to answer the questions below

I would like to be on SisterHermana Foundation's mailing list?

Yes No

How did you hear about SisterHermana Foundation?

— Social Worker Name: _____________________________________

— Nurse Name: ______________________________________

— Oncologist

— Patient Financial Counselor

— Patient Navigator

— Friend Name:_______________________________________

— Internet

— Brochure

Other:____

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

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____

Household Information Form

If applicable please list all children under 18

Name	Age	Grade	School	Birthday

Do you have a church affiliation? ____

Do you rent or own your home? Rent Own

If you own your home are you in need of any minor repairs? Yes No

If your answer is yes what minor repair are you in need of?_________________________

____

Where do you have your prescription's filled? _____________________________________

Do you have transportation to and from appointments and treatments? Yes No
Most times

Would you allow someone to come into your home and clean for you? Yes No

If you stated yes to the above question are there any customs we should inform our volunteer of? IF yes please explain. Yes No

____
____
____

Does anyone in your family have food allergies? Yes No

Please list all food allergies

____

____

____

Please list any foods that your family does not eat.

____

____

____

Are you on a special diet? Yes No

Please place check next to the items to indicate any additional services you would be interesting in receiving upon availability. (Please note you must sign a waiver before participation)

	Having my yard cut
	Having my son's haircut
	Having my daughter's hair maintained
	Receiving a Thanksgiving or Christmas Basket
	Receiving Christmas Gifts
	Receiving birthday cakes for myself or my family members
	Having my car washed
	A ride to treatment
	Activity books and games for my children
	A family night out
	Having my home cleaned
	A Weekly visit
	Sunday dinner for my family
	Manicure and/or pedicure
	Visit me if I'm hospitalized
	Tutor to make sure my child stays on task
	Meal delivered any day of the week for my family
	Dry cleaning
	Laundry services

Photo and Multimedia Release

I ____ grant permission to SISTER HERMANA FOUNDATION, INC and persons acting for or through them, the right to use, reproduce, and/or distribute photographs, films, videotapes and sound recordings involving the participation of the individual identified on this form at SISTER HERMANA FOUNDATION, INC for use in promotional materials that may be created.

____________________________________ ______________________________

Signature Date

I acknowledge I understand that:

________ Services provided by SisterHermana Foundation are based upon availability.

________ Volunteers are **not** permitted to be left alone with minor children at the house or at barbershops or beauty salons.

________ Any bills rendered on my behalf will be paid directly.

________ If approved any assistance we can provide pending availability will expires after 120 days.

Signature:____ Date:_________________