



# Grant Application

*Each time we help fund a cancer patient's care, we give hope wings.*

Dear Applicant

AnthioGen, a non-profit organization in Denver, Colorado, funds individual patients to support payment of insurance and/or COBRA payments. The following information is required to evaluate the need for funding to each patient requesting financial support. All contents of this application will be kept confidential and will be presented to AnthioGen board members only. Go through the checklist to aid in speedy response and review of your applications:

#### Checklist

- ✓ Application - Fill out application with healthcare provider
- ✓ Cover letter explaining your situation or anything you feel AnthioGen should know
- ✓ Contact numbers – give the best numbers we can reach you at
- ✓ Insurance Premium / COBRA statements

*The application must be completed and signed by a healthcare professional (i.e., case worker, patient navigator, social worker, nurse, physician's assistant of physician) who is familiar with the patient's diagnosis and treatment.*

Once completed, the form may be mailed, faxed or emailed to:

AnthioGen  
4350 Wadsworth Blvd #350  
Wheat Ridge, CO 80033  
Phone: (303) 808-5872  
Fax: 303-953-7401  
Email: [Earth.Angels@AnthioGen.org](mailto:Earth.Angels@AnthioGen.org)

Upon receipt of your complete application, our Application Committee will evaluate the patient's eligibility and inform you of their decision. Applications are reviewed the third Tuesday of the month and a response is given within a week of the review. If your application is approved, payment will start the month we received the application and all documentation.

What specifically AnthioGen provides:

- Three to six months' payments of health care insurance or COBRA premiums annually
- Up to \$3,000.00 in funding annually
- Limits of up to six month's insurance premiums or maximum assistance of \$3,000.00, whichever occurs first
- A patient can apply and receive a grant up to twice in a lifetime. Each instance must be in separate calendar years

# Patient Background

General Background			
Name		Home Phone	Sex
Home Address		City	State   Zip
Email		Mobile Number	
Describe your diagnosis and current situation?		Last date of treatment	
Have you applied for assistance through another organization? <input type="checkbox"/> Yes <input type="checkbox"/> No		With who?	
What was the result?		How much financial assistance are you seeking? (\$/mo)	
How will the assistance be used? r COBRA Payments r Insurance Premiums r Other (explain)			
Insurance Information			
Insurance Provider		Insurance Number	Coverage Effective Date   Monthly Premium Cost
Do you have Medicaid, Medicare or Other Insurance Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No      {Type}      {ID#}			
Primary Care Physician	Practice Name		Contact Number
Oncologist	Practice Name		Contact Number

**Household Member Information**

Name	Relationship	Age	Income	Insurance Provider

**Employment**

Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer Name?		
Work Address		City	State	Zip
Occupation		Monthly Income		
If unemployed, do receive unemployment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Monthly Unemployment Income		
Do you receive disability? r Yes r No		Monthly Disability Income		
DO you receive Veteran benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		Monthly Veteran Benefit Income		
Do you receive Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No		Monthly Social Security Income		
Do you receive other monthly income? <input type="checkbox"/> Yes <input type="checkbox"/> No {Explain}		Other Monthly Income		
Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Employer Name?		
Occupation		Monthly Income		

Financial Assessment			
Do you own a home? <input type="checkbox"/> Yes <input type="checkbox"/> No	Checking Account Balance	Savings Account Balance	
Do you own a business? <input type="checkbox"/> Yes <input type="checkbox"/> No	Explain you business's current situation		
Value of stocks or bonds	Value of 401K savings	Value of other real-estate outside of primary home	
Expenses			
Rent / Mortgage Payment	Monthly Utility	Monthly Food	
Childcare / Support	Car Payment	Car Insurance	
Credit card payments	Property Taxes	Other Expenses {Explain}	
Medical Expenses			
Premium Costs (including COBRA)	Monthly Medication Expenses	Monthly Co-pay Expenses	
<b>Medications</b>		<b>Dosing Schedule</b>	<b>Start Day</b>
Home Care			
Caring Company			
Address		City	State      Zip
Contact Person		Phone Number	
Start Date		Visits per week	

Cancer Patient Name Printed \_\_\_\_\_

Cancer Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Healthcare Provided Name Printed \_\_\_\_\_ Title \_\_\_\_\_

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_



**Send To:**

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While there is no obligation, AnthioGen would like to hear about your experience and the impact AnthioGen's services have made on your life. Please forward a letter or note with your story to help us promote how AnthioGen can support the Colorado community. At your request we will keep your name confidential.

Based on AnthioGen's current mission and vision, the following guidelines are considered and followed in assessing cancer patient qualification for grants and funding:

1. All applications are reviewed by the Board of Directors of AnthioGen, Inc., and the Board, in its sole discretion, will make the final decision about whether to provide assistance to an individual applying patient.
2. The Board of Directors consider many factors, including the patients and/or households' income in relation to their expenses, the patients diagnosis and current status of treatment, and the potential impact of the grant on the care and life
3. Each board member votes independently based on their history, experience and view of the given patients situation.
4. The patient must be at least 18 years of age, a resident of the state of Colorado and actively receiving treatment for his/her cancer.
5. By accepting and taking under consideration a patient's application for assistance, AnthioGen, Inc. makes no promises or commitments to or contracts with the patient that it will provide any assistance to the patient.
6. In making its determination whether to provide assistance to a patient, the Board of Directors of AnthioGen, Inc. will rely on the completeness and accuracy of the information provided in this application. In the event AnthioGen learns that any material information provided by a patient in the application is missing and/or inaccurate, AnthioGen, Inc. reserves the right to deny any such application. In the event that AnthioGen, Inc. has already determined to provide assistance to a patient who has submitted an application with material omissions and/or inaccuracies, AnthioGen, Inc. will have the right to immediately discontinue assistance.
7. In the event that AnthioGen, Inc. determines to provide assistance to a patient, AnthioGen, Inc. will provide that assistance in the form of direct payments to the appropriate health care insurance provider or its agent on behalf of the patient.
8. In the event that AnthioGen, Inc. determines to provide assistance to a patient, that assistance will not exceed three months' payments of health care insurance premiums on behalf of the patient; however, in no event will the total assistance provided by AnthioGen, Inc. exceed \$3,000.00. In the event that the health care insurance premiums funded by AnthioGen, Inc. include healthcare insurance for individuals in addition to the patient, the foregoing limits of three month's insurance premiums or maximum assistance of \$3,000.00, whichever occurs first, shall nevertheless apply.