



familiesCAN[™] Application for Assistance

If you are a family of a cancer patient and have non-medical expenses that you cannot meet, perhaps we can help.

FamiliesCAN is a 501(c)(3) non-profit organization run by the Ronald Whittier Family Foundation. It is dedicated to assisting families of adult cancer patients in the San Francisco Bay Area who are facing financial difficulties as a result of treatment.

If you or a family member require assistance in completing this form (i.e., for health- or language-related reasons) please phone 650.948.8268 and we'll arrange to have a FamiliesCAN representative help you.

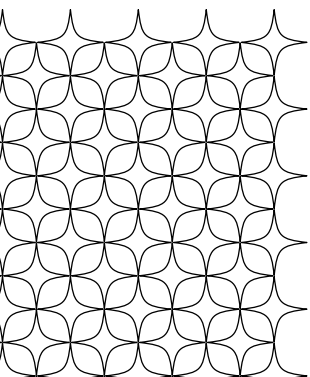
Please complete this application and send it to:

familiesCAN[™]

The Ronald Whittier Family Foundation

P.O. Box 1887

Los Altos, CA 94023





July 2001

Dear FamiliesCAN Applicant,

Some people think that my family's experience in dealing with cancer is remarkable. My husband began treatment for cancer a week before our first child was born. We were uprooted from our Bay Area home while he received treatment in Southern California. Once our daughter was born, we flew back and forth, living in hotels during the nine-month process.

Fortunately for my family, my husband has since recovered and returned to work. We have had another child. And our life together as a family has moved forward—but not without living through quite an ordeal. Our experience is more typical than remarkable. People's worlds are turned upside down during cancer treatment, and many people face economic burdens associated with the treatment that can be overwhelming.

I cannot imagine going through this experience and also having to worry about my family's most fundamental economic needs—whether the rent or mortgage would be paid, the children cared for, a semblance of normalcy and peace maintained for every one involved.

We founded FamiliesCAN to meet these needs. We provide families with both financial assistance for non-medical expenses—helping bridge the economic gap during treatment—as well as hands-on assistance in securing needed services. We evaluate requirements on a case-by-case basis and then provide funding and/or assistance to those families deemed most critically in need.

We will carefully and thoughtfully evaluate your application. Whether you are chosen to be a FamiliesCAN gift recipient or not, I wish you and your family strength in the coming months and a return to good health.

*Jacqueline Whittier Kubicka
President and Founder, FamiliesCAN
The Ronald Whittier Family Foundation*

We understand that you've come to FamiliesCAN for help. And it is our goal to provide just that—financial assistance for non-medical expenses during the cancer treatment and recovery process as well as help in securing necessary non-medical services.

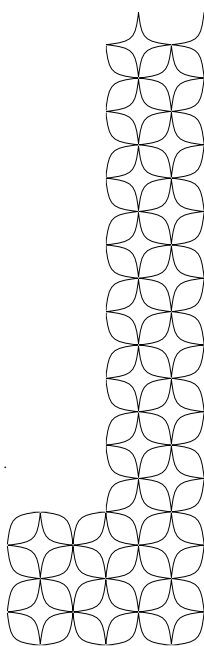
While we would like to come to the aid of all families in need, we have focused our efforts specifically on partnering with families that meet the following criteria:

- 1) Patient is currently receiving cancer treatment or will receive treatment within the next three months.
- 2) Patient must be an adult between the ages of 18 and 65.
- 3) Family has one or more dependents under the age of 25. Dependent must be an immediate family member.
- 4) **Patient is receiving treatment in a hospital in Santa Clara County.**
Patient must reside in the San Francisco Bay Area (counties: Santa Clara, San Mateo, Alameda, San Francisco, Contra Costa, Marin) or, if not a resident, must be receiving a minimum of four weeks on-site treatment in Santa Clara County.
- 5) Patient must be a U.S. citizen.

The applicants whom we select are those deemed “most critically in need.” We consider your financial situation (income level, as well as amount of indebtedness created as a result of cancer treatment) as well as personal circumstances (dependents, employment, etc.). Generally the patient's medical prognosis is not of primary consideration, although patients who need extended treatment or have more advanced disease often have a greater financial need.

The information that you provide in this application will be used merely to determine need for our help. It will be reviewed by the FamiliesCAN Application Committee and will not be divulged to anyone else without your permission. If accepted, you will be asked to verify information contained in this application.

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Applications are reviewed by the committee approximately every four weeks.

Here are some things that you will want to keep in mind if you are offered assistance from our program:

We will notify in writing those families that we are able to help. We will provide you with a written summary of the expenses that will be covered and a payment schedule for those monies. If services are to be provided, we will work with you to ensure that the services are properly set up and executed (you will have to screen and select the service provider but we can help with the follow-up).

If you are granted a cash gift, you will be required to provide proof that your gift is used in the manner specified when the agreement was made.

We expect that, in addition to applying to FamiliesCAN for support, patients will take advantage of any existing financial support that is already available (example: if you are requesting assistance for an educational program for your child, have you also applied for scholarship money or financial assistance?). FamiliesCAN may ask your permission to contact service organizations on your behalf regarding reduced rates for their services.

If you are selected, we welcome the opportunity to meet with you and/or your family in person. Though this is not a condition of being accepted into the program, face-to-face conversation can help us to better understand how we can help you.

We would like to bring the following to your attention:

- 1) Gifts from FamiliesCAN may interfere with other benefits that you receive (example: MediCal, HUD housing, T.A.N.F., etc.). It is your responsibility to ensure that, by accepting this gift, your benefits are not adversely affected or terminated.
- 2) You may wish to inform your tax advisor that you are accepting a gift from FamiliesCAN. He/she will be able to assist you in determining whether acceptance of this gift constitutes a taxable event.

Thank you.



Personal Information

Patient's Name {*First*} {*Last*}

Female Male D.O.B Age

Social Security Number

Street Address

City State County

Zip Code

Home Phone Business Phone

E-mail address

Are you a U.S. citizen? *Yes* *No*

Note If selected to participate in this program, you will be asked to provide proof of citizenship.

If you/your family are already residing near the hospital site, where are you staying?

Phone

Frequently we have questions regarding your application. What is the best way(s) to contact you?

In-person meeting at hospital

Phone

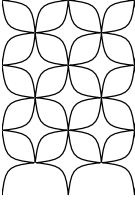
E-Mail

Mail

Should we contact you directly or do you prefer that we speak to another family member?

Relationship to you?





Family Information

Spouse's Name	{First}	{Last}	
Dependent's Name	{First}	{Last}	Age
Dependent's Name	{First}	{Last}	Age
Dependent's Name	{First}	{Last}	Age
Dependent's Name	{First}	{Last}	Age

Are children living at home?

If not, with whom are children living ?

Is this the normal living arrangement, or temporary due to cancer treatment?

If not, who normally supervises the children during the day?

Have special arrangements been made for children's supervision during the cancer treatment?

If you travel away from home for extended cancer treatment, will the children accompany you?

Please indicate where the children attend school:

Child's Name	School	Public/Parochial/Private/etc.	# Days/Week

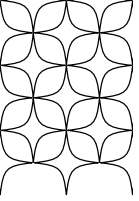
Other information regarding children:

Please answer if you are requesting tuition assistance:

Is the school aware of the patient's illness?

If selected for this program, would you be willing to allow FamiliesCAN to contact the school regarding tuition arrangements (this often includes a request for reduction in monthly tuition rates— FamiliesCAN and the school partner in covering your child's tuition cost)?

Do you use pretax money to pay for any of your childcare?



Medical Information

Date of Diagnosis

Diagnosis

Further description of disease

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.....

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Is this a recurrence? *Yes* *No*

Briefly, what is the treatment plan?

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When is the treatment plan expected to begin?

When is the treatment plan expected to end?

How many days do you expect to spend as an inpatient?

..... days (# of days) x visits (# of visits) = total # of days

How many days do you expect to spend away from home in local housing (i.e., hospital housing, near-

by hotel, etc.)? days (# of days) x visits (# of visits) = total # of days

Is there a predefined or expected recovery period during which time the patient will not be able to work or participate in normal activities?

Other information regarding length of treatment:

.....

.....

If you currently visit the hospital/doctor's office for regular treatments (i.e., chemo, radiation, etc.), how often do you visit?

On what day(s) of the week do you visit?

What is your scheduled return to work date?

Who is your health insurance provider?

.....

.....

Name of Physician

Institution Phone

Address

E-mail Address

Name of Social Worker (if applicable)

Institution Phone

Address

E-mail Address

Did your social worker either help you complete this form or review this form prior to mailing?

Note In determining your eligibility for the FamiliesCAN program, the information in this application may be discussed/verified with doctors and social workers.

Financial Information

Patient's Employer

Occupation

Address

Dates of Employment

Phone

Currently working? *Yes* *No*

If working, is your schedule reduced (or will it be in future) due to cancer treatment?

What is the amount of hours of the reduction?

Are you currently on a leave of absence? *Yes* *No* *Paid or unpaid?*

Spouse's Employer

Occupation

Address

Dates of Employment

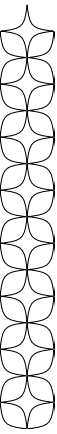
Phone

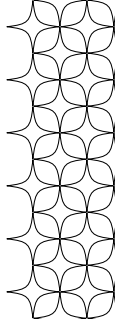
Currently working? *Yes* *No*

If working, is your schedule reduced (or will it be in future) due to cancer treatment?

What is the amount of hours of the reduction?

Are you currently on a leave of absence? *Yes* *No* *Paid or unpaid?*





Below, please list all sources of income including disability, sick leave pay, child support, etc.:

What was your family's **annual gross income** prior to diagnosis/treatment?

For Calendar Year: (example: 2000)

Please note all sources of income:

Source	Annual Amount
Source	Annual Amount
Source	Annual Amount
Source	Annual Amount
TOTAL	

What do you expect your family's annual gross income to be during the treatment?

Please note all sources of income:

Year:

Source	Annual Amount
Source	Annual Amount
Source	Annual Amount
Source	Annual Amount
TOTAL	

Please identify all sources of investments and savings (securities, including stocks and bonds; savings accounts; IRAs; 401K; CDs; etc.):

Source	Amount
Source	Amount
Source	Amount
Source	Amount
TOTAL	

Has money been raised on behalf of the patient or immediate family? *Yes* *No*

How much money has been raised?

How is the money being used?

Please list normal living expenses that you must cover (examples: rent/mortgage, car payment, educational or childcare expense, child support — please just list the most substantial items):

Year:

Rent/Mortgage	Annual Amount
Expense	Annual Amount
Expense	Annual Amount
Expense	Annual Amount
Expense	Annual Amount

Do you live in HUD housing or other financially supported housing?
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Do you receive any form of government assistance (T.A.N.F., etc.)?
.....

Additional comments regarding financial situation:
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.....
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Note If you are offered assistance from the FamiliesCAN program, this information must be verified and you will be asked to provide a recent tax return.

Types of Assistance

The FamiliesCAN program will consider financial assistance for non-medical expenses that cannot be met as a result of the patient's treatment. We cover a wide variety of expenses, including but not restricted to the following: Travel Expenses; Lodging; Household Expenses; Mortgage/Rent; Childcare; Educational Expenses; Housekeeping Expenses; Counseling Services; Attendant Care; Recreational Expenses. We prefer that there be a FOCAL POINT to the gift rather than paying for a number of disparate miscellaneous expenses. What are one or two really big things that would have a SIGNIFICANT IMPACT if we were to cover? Examples: travel and lodging during treatment; educational expenses and care for the children during treatment; care for me and my family (attendant care/respice care) during treatment; payment of mortgage/rent during treatment (because I cannot work, etc.).

Item requested for financial assistance
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Dollar amount
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Description
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.....
.....

Item requested for financial assistance
.....

Dollar amount
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Description
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Please attach an additional sheet of paper if there are more expenses to outline.

Patient Signature

The undersigned or the anticipated recipients of the funds wish to participate in the benefits provided by FamiliesCAN.

We understand that our participation in such a program is wholly voluntary and that these benefits are provided by FamiliesCAN in furtherance of its humanitarian endeavor to provide financial support to families of cancer patients.

We hereby assume all risks and responsibility for any damage or injury, physical or emotional (including the aggravation of any existing illness or condition), which we or our family may sustain as a result of our participation in the benefits provided by FamiliesCAN, its volunteers, officers, directors, agents, sponsors, advisors, members, and employees.

We hereby release, discharge, indemnify, and agree to hold harmless FamiliesCAN, its volunteers, officers, directors, agents, sponsors, advisors, members, and employees, from all claims, demands, causes of action, present and future, whether known, anticipated or unanticipated, resulting from, arising out of, or incidental to our participation in the programs or benefits provided by FamiliesCAN.

All information is and remains confidential. It will be used only: 1) in connection with the application process for the purpose of determining suitability of the applicant and 2) in the process of establishing services on behalf of the patient (school tuition, attendant care, etc.).

I hereby certify that all the information provided on this application is true.

Patient Signature

Date

Authority to Release Hospital Records and/or Divulge Medical Information

Doctor/Hospital

Social Worker/Hospital

In regard to your patient named

Age

D.O.B

You are hereby authorized to furnish and release to FamiliesCAN, a non-profit organization which provides non-medical expense help to families of cancer patients, all information and records requested regarding findings, treatment rendered, and opinions as to my condition. The foregoing authority shall continue in force until revoked by me in writing.

Patient Signature

Date