Program Director: 805-563-4785 Main Line: 805-962-7466

Teddy Bear Cancer Foundation
Application for Financial Assistance

Eligibility Requirements

1. Any child residing in the Tri-County Region (Ventura, Santa Barbara or San Luis Obispo counties) diagnosed with cancer before his/her 18th birthday and treated before his/her 21st birthday is eligible for consideration. If child should relapse before their 18th birthday they are eligible to re-apply for additional financial assistance.
2. Applicant needs to resubmit a new Financial Assistance Application each calendar year if further financial assistance is needed.
3. Priority consideration will be given to families projected to be low to moderate income per the U.S Department of Housing and Urban Development (HUD) state and county limits.
4. All sections of this application must be completed accurately. Failure to provide complete and truthful information is a basis for denial.
5. Provide completed application to hospital professional (i.e. social worker) who will forward to TBCF. In the event the application cannot be provided to a hospital professional, please email application or USPS mail to Teddy Bear Cancer Foundation's Program Director, Becca Solodon

Application can be sent via:
Email:becca@teddybearcancerfoundation.org
USPS mail address: 3892 State St., Ste 220, Santa Barbara, CA 93105
For questions: (805) 563-7485

Required Documents: (for each parent who claims child as dependent)

Acceptable Proof of Income and Residency	
If family receives Medi-Cal services for the current year please provide the following documents:	• Proof of Medical coverage (copy of Medi-Cal Card) • Proof of residency in Tri-County Region (e.g. copy of identification card, utility bill, paycheck stub, voter's registration card, car registration, or copy of car insurance)
If family receives private insurance coverage please provide the following documents:	• Copy of most recent pay stub(s) – if applicable • Proof of additional sources of income –if applicable (e.g. SSI, child support, unemployment benefits, self-employed) • Proof of residency in Tri-County Region (e.g. copy of identification card, utility bill, paycheck stub, voter's registration card, car registration, or copy of car insurance)
Supplemental Documents	
• Letter of recommendation from social worker • Prior year's tax return	

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CHILD/PATIENT INFORMATION

First name:_____ Last name: _____

Date of birth:_____ Place of birth (state/country): _____

☐ Male ☐ Female | **Ethnicity:** ☐ Caucasian ☐ African American ☐ Latino/a ☐ Asian ☐ Other: _____

Name of parent/guardian: _____

Name of parent/guardian: _____

Permanent address (street/city/zip): _____

Permanent phone:_____ other phone:_____ email:_____

Please consider sending a photograph of your child with the application or by email to:
becca@teddybearcancerfoundation.org

MEDICAL INFORMATION

Child's diagnosis:_____

Date of diagnosis:_____ Primary type of cancer: _____

Date of initial treatment:_____ Projected length of treatment:_____

SOCIAL WORKER OR HEALTH CARE PROFESSIONAL INFORMATION

First name:_____ Last name: _____

Hospital/Clinic: _____

Address:_____ City, State, Zip:_____

Phone: (_____)_____ Fax: (_____)_____

Email address:_____

PATIENT FUN FACTS

Favorite food:_____ Favorite color:_____ Favorite song: _____

Favorite cartoon character:_____ Favorite TV show: _____

Favorite book:_____ Favorite sport: _____

If I could go anywhere in the world, I would go to_____

HOUSEHOLD INFORMATION

List name, age, and relationship to patient of ALL **dependents** (include parents, children and any other dependents).

1. _____ Age_____ Relationship_____
2. _____ Age_____ Relationship_____
3. _____ Age_____ Relationship_____
4. _____ Age_____ Relationship_____
5. _____ Age_____ Relationship_____
6. _____ Age_____ Relationship_____

List name, age, and relationship to patient of ALL other **household members** (grandparents, uncles/aunts, etc.)

1. _____ Age_____ Relationship_____
2. _____ Age_____ Relationship_____
3. _____ Age_____ Relationship_____
4. _____ Age_____ Relationship_____
5. _____ Age_____ Relationship_____
6. _____ Age_____ Relationship_____

HOUSEHOLD INCOME AND EXPENSES INFORMATION: *Employment*

Parent/Guardian #1:

Employer:_____ Current gross monthly salary: _____

Address: _____ Phone: _____

Is father or guardian currently on unpaid leave? Yes No
Is father or guardian currently unemployed? Yes No

** If unemployed or on unpaid leave, please attach proof for the current year.*

Parent/Guardian #2:

Employer:_____ Current gross monthly salary: _____

Address: _____ Phone: _____

Is mother or guardian currently on unpaid leave? Yes No
Is mother or guardian currently unemployed? Yes No

** If unemployed or on unpaid leave, please attach proof for the current year.*

GROSS ANNUAL HOUSEHOLD INCOME

What is your family's **projected gross annual household income** (current year)? $ _____

What was your family's **gross annual household income** in the previous year? $ _____

MONTHLY HOUESHOLD EXPENSES

How much does your family spend on the below items each month?
Feel free to provide a ***projection*** of each expense.

Housing

(Please Circle One): Rent / Own

Monthly payment: $ _____ Utility bills: $ _____

Groceries: $_____

Transportation

Gas/fuel: $ _____ Repairs/insurance: $_____

Other *(household items not related to treatment):* $ _____

Expenses Related to Treatment

Medical bills (not covered by insurance): $_____

Hotel/Temporary housing: $ _____

Gas/fuel to travel to treatment: $ _____

Other *(clothing, household items, miscellaneous):* $ _____

Would you like to share any other income or expense information with TBCF?_____

_____

OTHER FORMS OF INCOME OR FINANCIAL ASSISTANCE

List the name(s) of the organization(s) currently providing financial assistance to your family.

Organization's name: _____ Amount (optional): $ _____

Organization's name: _____ Amount (optional): $ _____

Organization's name: _____ Amount (optional): $ _____

Organization's name: _____ Amount (optional): $ _____

Organization's name: _____ Amount (optional): $ _____

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Financial Support Program

- **Direct Financial Assistance (DFA):** Families can apply for up to $5,000 for payment of rent or mortgage; auto loans, registration, insurance, and repairs; utility bills; hotel accommodations, medications and home care services not covered by insurance; counseling, and child care. We can also provide gas, grocery and hospital cafeteria gift cards, or reimburse families those expenses with submission of a receipt of purchase. Bills are paid directly by TBCF. All bills must include name of dependent (s), address of vendor, total amount due, and account number information. If family wishes to cover the cost of rent, family must submit a W9 form to TBCF before rent payment can be made. If child should relapse before their 18th birthday they are eligible to reapply once for additional financial assistance.

- **Education Support:** To help families address learning problems that are a common side effect of chemotherapy, TBCF covers up to $1,500 for the cost of neuropsychological testing and up to $500 for tutoring by credentialed teachers.

Emotional Support Program

- **Family Support Groups:**

  Santa Barbara: Co-sponsored by the Leukemia & Lymphoma Society, TBCF provides bilingual support group for parents, as well as expressive art and discussion groups for the child with cancer and their siblings

  Ventura: In a joint collaboration with the Ventura County Medical Center Pediatric Hematology/Oncology Clinic; Community Memorial Hospital Cancer Resource Center; The Wellness Community Valley/Ventura; St. John's Cancer Center of Ventura County, Leukemia & Lymphoma Society and American Cancer Society, TBCF provides bilingual support groups for parents, as well as expressive art and discussion groups for the child with cancer and their siblings.

  Santa Maria: In a joint collaboration with the Marian Cancer Care at Mission Hope Cancer Center, TBCF provides bilingual support groups for parents, as well as expressive art and discussion groups for the child with cancer and their siblings.
- **"Bear" Necessities:** TBCF provides families with items such as furniture, appliances, clothing, or bedding, as well as diapers and wipes for families with little ones.
- **Family Fun Events:** We host fun events and trips for children and their families throughout the year, such as Family Fun Days.
- **Holiday Party:** TBCF hosts Cottage Hospital's Pediatric Holiday Party, creating an opportunity for children in treatment and their siblings to visit with Mr. & Mrs. Claus while receiving a gift.
- **Care for the Caregivers:** Our Mother's Spa Day and Fishing for Fathers events focus on pampering the caretakers.
- **TBCF Storytellers:** Each week, volunteers read stories to children in pediatrics at Cottage Hospital. We also offer free books and toys for the children to keep.

Holiday Support

Project Holiday: Each year, families are selected based on need to be part of Project Christmas, Project Turkey, and Project Easter. Families receive holiday gifts, such as toys, games, and clothing; Easter baskets; Christmas trees and decorations; pre- made Thanksgiving dinners, grocery vouchers; and more! All items are provided by donors, put together by volunteers, and delivered to families' homes or kids at the clinic who are receiving cancer treatment.

Community Outreach Program

Bone Marrow Drives: In collaboration with Be the Match Registry, we help coordinate bone marrow drives to benefit families in search of a match for their child.

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Financial Assistance Program Request Form

(Check all that apply)

$2,500: ***Direct Financial Assistance Starting Amount***

Each qualifying family if approved will receive a minimum of $2,500. Please use the boxes below to indicate additional funding eligibility qualifications. If at any time a family becomes eligible for additional funding within their allotted year-long account with us, further funding may be requested. The maximum amount of funding that can be granted is $5,000.

Additional Funding Qualifications: ***Check All that Apply***

- ☐ $2,500 If Bone Marrow Transplant is Needed
- ☐ $750 If Significant Loss of Income (*Reduction of 20 hours+ per week*)
- ☐ $500 If Length of Treatment is Longer than One Year
- ☐ $500 If Single Parent Household *(not receiving child support)*
- ☐ $500 If Hotel Accommodations are Needed
- ☐ $500 Special Circumstances *(examples: eviction/move, cancer or other serious illness within additional immediate family member, car breaks down)*

Total Amount Requested: ***Initial $2,500 + Any Additional Qualifications =*** _____

Education Support Program:

- ☐ $1,500 Neuropsychological Testing
- ☐ $500 Tutoring

TBCF Office Use ONLY

Program Applied For	Amount Granted	Date Granted	Program Director (Initials)
Direct Financial Assistance			
Education Support			
Other:			

Name of Patient: _____

Name of Guardian(s): _____

Family Number: _____

Completed Application Received (date): _____ Effective Date: _____

Six Month Reminder: _____ Expiration Date: _____

Program Director (Signature): _____ Date: _____

Executive Director (Signature): _____ Date: _____

TERMS AND CONDITIONS

CONSENT TO RELEASE INFORMATION

By signing this form, I understand and agree to the terms stated below:

- ❑ Teddy Bear Cancer Foundation will pursue restitution for grants if it is determined that the information submitted on the application is false.
- ❑ I have read the Financial Assistance Eligibility Requirements and I declare that the information furnished on this application form, including attached documents, is true and correct to the best of my knowledge.
- ❑ Teddy Bear Cancer Foundation reserves the right to deviate from the Guidelines when special needs arise.
- ❑ All information disclosed on this form is confidential.

I do hereby authorize all hospitals, financial institutions and insurance groups and/or carriers to release to Teddy Bear Cancer Foundation, or its duly authorized representative, any information Teddy Bear Cancer Foundation deems necessary to complete its investigation on my application for financial assistance.

Signature of Parent or Guardian_____ Date_____

Printed name _____

Signature of Parent or Guardian_____ Date_____

Printed name _____

WAIVER AND RELEASE OF LIABILITY

I,_____, acknowledge that I have authorized for myself, and/or my child/children,_____, of whom I am the legal guardian or parent, to participate in the activities and events put together by the Foundation.

In consideration of the Foundation allowing me and/or my child(ren) to participate in this event, I, for myself, and on behalf of my spouse, child(ren), guardian, heirs, next of kin and any legal representatives, herby agree to each of the following:

1. ____I consent to the recording, use and reuse by the Foundation of my voice, image, actions, likeness, name, and appearance in any Foundation publication and/or for the Foundation's fundraising purposes in newsletters, letterhead, internet postings, website design, pamphlets, flyers, or other publications. I am voluntarily allowing myself and/or my child/children to participate in these activities with knowledge of this potential publication and/or fundraising use. **I am aware that neither I nor my child/children, nor any person other than Teddy Bear Cancer Foundation, will receive any benefit, monetary or otherwise, from any of my and/or my child's/children's photographs or other activates offered by Teddy Bear Cancer Foundation.**
   I hereby agree to accept that this publication and/or fundraising may occur under these terms, and verify this statement by placing my initials here: _
2. ____I hereby agree that I, my assignees, heirs, distributes, guardians, and legal representatives, will not make a claim against, sue, or attach the property of the Foundation, or any of its affiliated organizations, directors, officers, or employees for any injury, damage, or loss resulting from the publication of any drawings, photographs, writings, interviews, or other activities.
3. ____I acknowledge and assume all of the risks and aspects of the activities and events put on by the Foundation. I acknowledge that I and/or my child(ren) will be participating at our own risk, and HEREBY WAIVE, RELEASE, CONVENANT NOT TO SUE, INDEMINIFY AND FOREVER DISCHARGE the Foundation and any of its affiliated organizations, directors, officers, and employees from all actions, claims, demands and causes of action that I, my assignees, child(ren), spouse, heirs, distributes, guardians, and legal representatives now have or may hereafter have for any injury, damage, or loss resulting from my participation or my child's/children's participation in any activities of the Foundation.

WAIVER AND RELEASE OF LIABILITY

I have carefully read this agreement and fully understand its contents. I am aware that this is a release of any potential liability and a contract between myself and Teddy Bear Cancer Foundation and/or its affiliated organizations and sign it of my own free will.

Executed at_____, California, on_____20____

_____

Signature of release

Declaration of Witness

I certify that_____[*Name of releaser*] acknowledged in my presence that he/she had read and fully understood the meaning and consequences of the foregoing release and signed it in my presence.

Executed at_____, California, on_____20____

_____

Signature of witness

_____

Printed name of witness