Date received:

HOPE HARVEST CANCER FUND

GRANT APPLICATION

****

Once completed, please mail to the Community Foundation of San Benito County,829 San Benito Street #200, CA 95023. If you have any questions regarding this application, please call 831-630-1924.

**Type or print clearly**

**Name of Applicant**

# Type of Request

 Food

 Gas assistance

 Child Care

 Mortgage/Rent Assistance

 Utilities Assistance

 Other, Please Specify

# Amount Requested

# Maximum amount available for granting per household is $10,000 per year.

# Has financial assistance been sought from additional sources? YES NO

# IF YES please add all assistance to “other income” on page three

# How did you hear about the HOPE HARVEST financial assistance grant?

1

# Applicant Information

|  |  |
| --- | --- |
| Last Name, First Name |  |
| Date of Birth |  |
| Gender |  |
| Address |  |
| City, State, ZIP |  |
| Home Phone |  |
| Cell Phone |  |
| Email Address |  |
| Employer |  |
| Employer Address |  |

**Spouse/Significant Other Information**

|  |  |
| --- | --- |
| Last Name, First Name |  |
| Date of Birth |  |
| Address |  |
| City, State, ZIP |  |
| Home Phone |  |
| Cell Phone |  |
| Email Address |  |
| Employer |  |
| Employer Address |  |

# Family Members Living in Household

|  |  |  |
| --- | --- | --- |
| NAME | DATE OF BIRTH | RELATIONSHIP TO APPLICANT |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**HOUSEHOLD INCOME**

**\*Please provide last 3 pay stubs.\***

Please include all persons contributing to household income.

**HOUSEHOLD INCOME**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Income** | **Current Month** | **Previous Month** | **Previous Month** |
| Monthly Gross Income | $ | $ | $ |
| Unemployment | $ | $ | $ |
| Social Security/Pension | $ | $ | $ |
| Alimony | $ | $ | $ |
| Other Income | $ | $ | $ |
| **TOTALS** | $ | $ | $ |

|  |  |
| --- | --- |
| Make/Year |  |
| Monthly Payment | $ |
|  |
| Make/Year |  |
| Monthly Payment | $ |
|  |
| Make/Year |  |
| Monthly Payment | $ |

Government Assistance: YES or NO (please circle)

|  |  |
| --- | --- |
| Estimated roundtrip mileage (if traveling byautomobile) |  |
| Number of individuals |  |
| Number of roundtrips/week |  |

Food Stamps: YES or NO (please circle)

**HOUSEHOLD VEHICLE INFORMATION**

**GAS ASSISTANCE REQUEST (for treatment sought out of town)**

**MONTHLY EXPENSES**

**HOPE HARVEST MAY REQUIRE PROOF OF YOUR EXPENSES LISTED**

|  |  |  |  |
| --- | --- | --- | --- |
| **Expense** | **Month 1** | **Month 2** | **Total** |
| Rent | $ | $ | $ |
| Mortgage | $ | $ | $ |
| Electricity | $ | $ | $ |
| Water | $ | $ | $ |
| Gas | $ | $ | $ |
| Child Care | $ | $ | $ |
| Internet | $ | $ | $ |
| Home Phone | $ | $ | $ |
| Cell Phone | $ | $ | $ |
| Clothing | $ | $ | $ |
| Food | $ | $ | $ |
| Entertainment | $ | $ | $ |
| Credit Cards | $ | $ | $ |
| Other Loans | $ | $ | $ |
| Health Insurance | $ | $ | $ |
| Healthcare Expenses | $ | $ | $ |
| Prescription Expenses | $ | $ | $ |
| Alimony/Child Support | $ | $ | $ |
| **TOTALS** | $ | $ | $ |

**Rent, Mortgage, Child Care, Utilities, General Household Exp, etc…**

**Include supporting documents/copies of bills(3 months)**

**Complete only the sections which apply to your request for financial assistance. Please include the correct and complete address where payments should be sent.**

**Upon approval, payments will be paid directly to the Mortgage company or Landlord. With the exception of gas and food will be administered through gift cards, funds will not be paid directly to the applicant.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of Assistance****Needed** | **Amount Requested** | **Payee Name** | **Account Number** | **Complete Address** |
| Rent/Mortgage | $ |  |  |  |
| Electricity | $ |  |  |  |
| Water | $ |  |  |  |
| Gas | $ |  |  |  |
| Home/Cell Phone | $ |  |  |  |
| Other | $ |  |  |  |
| **TOTAL** | $ |  |

# By my signature below, I declare that the information I have provided is accurate. I understand that financial assistance is not guaranteed.

I will continue to make my best attempt to pay my expenses while my application for assistance is being considered and processed.

#  \_ \_

Name Date

**HIPAA Release of Information**

**AUTHORIZATION FORM**

I, hereby authorize and its affiliates, it employees and agents (collectively ), to release to HOPE HARVEST, [Insert full name of person] my personal financial information and health information maintained by (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided

to me and which identifies my name, address, social security number, Member ID number) **except** the following information about me:

 **[DESCRIBE INFORMATION NOT TO BE**

**DISCLOSED, IF ANY]** for the purpose of helping me to resolve claims and health benefit coverage issues. I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my/my representative’s signature below and shall expire the earlier of **[INSERT DATE/EVENT UPON WHICH THIS**

**AUTHORIZATION EXPIRES]** or the date my coverage ends with .

I understand that I have a right to revoke this authorization by providing written notice to

 . However, this authorization may not be revoked if

 , its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

**Name of Member:**

**Signature of Member:**

**Date:**

**If applicable, Legal Representatives sign below:**

***By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with respect to this authorization form.***

**Name of Legal Representative:**

**Signature of Legal Representative:**

**Date:**

**Name of Witness:**

**Signature of Witness:**