ANSWERS FOR ANGELS' GRANT APPLICATION

For Child, Adult or Immediate Family Financial Support

Funding Request Guidelines

- Cancer patient/their immediate family member must complete this application IN FULL along w/Media Release & Testimony
- A $350 lifetime grant is awarded to a cancer patient or immediate family member.
- All candidates will receive an email/written letter regarding the approval/denial of the application request for financial support.
- The support grant is used for which **Answers for Angels pays the provider directly or provides a gift card/certificate** for the service. No cash grants are given to patient or family.
- You may apply multiple times until you receive the lifetime grant of $350.
- **Attach applicable bill(s)/invoice**. Black out private info. Answers for Angels' Board Members and/or Review Committee may request other documents upon review of this application.
- **Email/Mail this completed form along with the Media Release Form and Testimony Form** to KatieDavis@AnswersForAngels.com or mail to Answers for Angels, Review Committee, P.O. Box 607, Frankfort, IL 60423 (815) 600-3215

Full Name of Patient_____Date of Birth _____

Cancer Type_____Stage of Cancer_____

Caregiver Name_____Relationship_____

Other Names of Persons in Household (if applicable):

_____Age (if 18 yrs. & below) _____

_____Age (if 18 yrs. & below) _____

Address _____

Phone _____(cell)_____(home)_____(work)

Email Address _____

Purpose of Request:

The consultations that you have with an integrative, holistic, naturopathic doctor, can be requested for us to pay them for any future consultations. In addition, any bill in patient's name are funded to the provider. Gift Cards or Certificates are given as part of the support grant. Please check all that apply. If questions, please email KatieDavis@AnswersForAngels.com.

□ Gift Cards (Please specify)	□ Chiropractic Adjustments
□ Bills, **any, with patient's name** on it; i.e. medical, electrical, gas, phone, etc.	□ Oncology Acupuncture/Massage Gift Certificate
□ Consult w/Integrative Oncologist/Practitioner	□ Tickets to …(Please specify)
□ Certificate for Infrared Sauna treatment	□ Injections/Supplements from Integrative Oncologist
□ Other (Please specify)	□ All-access Pass to Sky Zone Trampoline

Describe Circumstances for Need (narrative): attach additional sheet or use other side if necessary

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Amount Requested $_____ Have you applied for funding previously with us? Yes/No If yes, was it approved? Yes/No

Signature _____Date_____

OFFICE USE ONLY
Date Application Received: _____