



## Board of Directors

Monika Brown  
Interim Board  
Chair/Secretary

Laurie Masera  
Garza  
Treasurer

Nadia Hakim  
Media/Marketing

Patty Schnabel  
Fundraising

Founders

Mrs. & Mrs. David  
Thomas

Honorary Chair  
Ryan Parsons  
Linduff

To whom it may concern:

Thank you for contacting Patient Housing Assistance to request financial assistance for your lodging during your treatment.

To determine if you qualify for assistance, see the chart below:

You are a Patient/Caregiver:	Household Size	Maximum Gross Family Income
	1	\$48,560 or less
	2	\$65,840
	3	\$83,120
	4 or more	\$103,900
You must be traveling for cancer treatment		
Treatment must be at least 50 miles, one-way, from your home		
You meet the income guidelines in the table to the right		
Verification of treatment form must be filled out by a clinician		

If you believe you qualify based on the above eligibility requirements, please return the following application as well as the supporting documents to the email address listed in the application. **Please note that a completed application is not a guarantee of receiving the assistance requested and may take up to 5 business days for notification of approval.** You MUST include financial documentation and verification of treatment by your doctor, nurse, or medical social worker. Your application will not be considered without the attachments.

If you have any questions, please feel free to contact us via phone **281.507.2035** or email [info@patienthousingassistance.org](mailto:info@patienthousingassistance.org).

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



Any information you share on the application is strictly confidential and for use by Patient Housing Assistance and its current Board Members only. Please do not

submit original documents with your application as we will not be able to return them to you.

Thank you!

Kind regards,

*Mr. & Mrs. David Thomas*

Mr. and Mrs. David Thomas  
Founders

Patient Housing Assistance

[www.patienthousingassistance.org](http://www.patienthousingassistance.org)

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



## HOUSING ASSISTANCE APPLICATION

This grant will provide eligible patients and/or their caregiving families financial assistance in the amount of \$250.00 - \$1,000.00 based on need and fund availability. Please be aware that the availability of “funds” may be limited, and we are working to assist as many patients as possible in a fiscal year. Once this application is approved, PATIENT HOUSING ASSISTANCE will remit payment directly to the lodging facility. **For tax reporting purposes, funds are not awarded to individual patients, individuals or companies such as VRBO, HomeAway or AirBNB.** If you have not secured lodging, we encourage you to view the medical housing list on Joe’s House at [www.joeshouse.org](http://www.joeshouse.org).

Please allow up to 5 business days for application notification. Please return the completed form to [info@patienthousingassistance.org](mailto:info@patienthousingassistance.org). If funding is awarded, funds must be used in their entirety, within 60 days of the award notification.

**If you need assistance with this application, please contact us at 281.507.2035**

## PATIENT INFORMATION

Today’s Date: \_\_\_\_\_

Patient’s First Name: \_\_\_\_\_ Patient’s Last Name: \_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_ MRN#: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed

Email Address:

---

Primary Mailing Address:

---

---

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Contact Phone number: \_\_\_\_\_

Estimated length of stay for treatment: \_\_\_\_\_ months

### HOUSEHOLD FINANCIAL INFORMATION

Eligible applicants must meet specific annual income guidelines. Annual income cannot exceed levels below:

Household Size	Maximum Gross Family
1	\$48,560 or less
2	\$65,840
3	\$83,120
4 or more	\$103,900

Number of people in patient's household: \_\_\_\_\_

Patient's gross annual household income: \_\_\_\_\_

Do you meet the eligibility requirements in the chart above? \_\_\_\_\_ Yes \_\_\_\_\_ No

If No, please **STOP** here. You are ineligible for assistance this time.

Does health insurance or Aflac reimburse for housing expenses? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please give a brief statement on how this assistance will impact you and your family.

---

---

---

---

Would you be willing to allow your statement to be shared with potential donors and grant applications? Only your first name and last initial will be shared.

\_\_\_\_\_ Yes \_\_\_\_\_ No

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



Have you received a donation/financial assistance from Patient Housing Assistance or any other organization within the last 6 months?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes when/from whom? \_\_\_\_\_

Funding is only possible through the generosity of others. Funds are generated through word of mouth and fundraising events. Would you be willing to follow and share Patient Housing Assistance on social media platforms such as Facebook to share our organization and story? Patient Housing Assistance is NOT a recipient of United Way Funding.

\_\_\_\_\_ Yes or \_\_\_\_\_ No

Please list any other sources of income (For example, GoFund Me campaigns on your behalf):

\_\_\_\_\_  
\_\_\_\_\_

Have you secured lodging?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please complete the next section. If approved, the funds will be remitted directly to the lodging company. **For tax reporting purposes, funds are not awarded to individual patients, individuals or companies such as VRBO, HomeAway or AirBNB.** If you have not secured lodging, we encourage you to view the medical housing list on Joe's House at [www.joeshouse.org](http://www.joeshouse.org)

Company Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Contact email: \_\_\_\_\_

***NAME AND RELATIONSHIP OF PERSON COMPLETING THE APPLICATION, IF DIFFERENT THAN ABOVE; IF SELF, PLEASE INDICATE AND DISREGARD THIS PORTION OF THE APPLICATION***

Name:

\_\_\_\_\_

Email Address:

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



---

Primary Mailing Address:

---

---

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_Spouse/Partner \_\_\_\_\_ Family Member/Caregiver \_\_\_\_\_Health  
Care Professional \_\_\_\_\_Other

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



## FINANCIAL DOCUMENTATION REQUIRED

**Please provide A COPY of at least one of the following:** the first two pages of last year's signed copy of your income tax return, a copy of your most recent paycheck, unemployment check, social security, SSI, SSD, or public assistance benefit notification. Please blackout your social security number if it appears on the document.

**Please provide A COPY of the patient's identification card/drivers' license.**

**\*\*\*APPLICATION WILL BE MARKED INCOMPLETE AND NOT PROCESSED IF NONE OF THE DOCUMENTS ARE PROVIDED\*\*\***

## APPLICANT AGREEMENT

I affirm the information above is true and correct. I understand, if I am awarded funds, that the award is a single, one-time gift. I understand I must use my gift within 30 days of my award, or the funds will be released to another patient.

None of the information from this application will be sent to anyone outside of Patient Housing Assistance. I understand and acknowledge that Patient Housing Assistance is providing this application solely for the purpose of assisting me with securing financial assistance for my temporary lodging. I understand that should my application be approved and I secure housing, that I will be subject to the lodging facility's terms and conditions in their entirety. In addition, I agree that I in no way will hold Patient Housing Assistance, its employees, Board of Directors, agents, or successors liable in any way in connection with this application, its approval or denial, or any of my interactions with the selected lodging facility.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Signature of Person completing application (if different from Patient):*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



## VERIFICATION OF TREATMENT FORM

**\*This page must be completed by your oncology doctor, nurse, or medical social worker\***

I hereby verify that I am doctor, medical social worker or nurse providing care and treatment of this patient and that he/she is or will be receiving active treatment for the following medical condition at \_\_\_\_\_ . The patient has the physical and mental health capability to travel a distance for their treatment or care.

Patient Name: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Type of Diagnosis: \_\_\_\_\_

Type of care or treatment patient is traveling for **(check all that apply):**

**Testing:** \_\_\_\_\_ Imaging \_\_\_\_\_ Biopsy \_\_\_\_\_ Blood Test \_\_\_\_\_ Biomarker testing

Other: \_\_\_\_\_

**Treatment:** \_\_\_\_\_ Chemo \_\_\_\_\_ Radiation \_\_\_\_\_ Targeted therapy \_\_\_\_\_ IO

\_\_\_\_\_ Stem Cell Transplant \_\_\_\_\_ Clinical Trials \_\_\_\_\_ Cellular therapy (CAR T or other)

\_\_\_\_\_ Surgery Other treatment: \_\_\_\_\_

Expected length of treatment: \_\_\_\_\_

Other: \_\_\_\_\_

Expected number of days in need of housing near the treatment center (Start of treatment):

\_\_\_\_\_

Name of destination treatment center: \_\_\_\_\_

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459





Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Phone number: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Treatment Center/Clinic: \_\_\_\_\_

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



CONSENT FOR PATIENT HOUSING ASSISTANCE TO CONTACT MY HEALTH CARE  
TEAM:

I hereby consent to the Patient Housing Assistance's contacting my doctor, medical social worker or nurse, identified above, to verify that I am in treatment for illness relative to my application to receive temporary housing assistance from Patient Housing Assistance. **I request that they complete this form, verify the information above, clarify if needed by Patient Housing Assistance, and return the form to me or Patient Housing Assistance.** This consent expires thirty (30) days after the date below.

---

Patient/Caregiver Signature

---

Date

**\*\*\*APPLICATION WILL NOT BE PROCESSED IF NONE OF THE FINANCIAL DOCUMENTS ABOVE  
ARE PROVIDED\*\*\***

The Patient Housing Assistance will review this application and contact the person that is requesting funds if additional information is required. All information is strictly confidential and is for Patient Housing Assistance use only and will not be shared.

*In loving memory of Ryan Parsons Linduff*

2601 Cartwright Rd Ste D #152, Missouri City, TX 77459



**\*\*\*FOR OFFICE USE ONLY\*\*\* BOARD APPROVAL**

M.B. - Secretary \_\_\_\_\_ N.H. - Media/Marketing \_\_\_\_\_ L.M.G. - Treasurer \_\_\_\_\_

P.S. – Fundraising/Development \_\_\_\_\_

D. Thomas - Founder \_\_\_\_\_ Y. Thomas - Co-Founder \_\_\_\_\_

Notification of Award to Patient \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

Notification of Award to Entity \_\_\_\_\_ Yes \_\_\_\_\_ No Date: \_\_\_\_\_

If application is denied, list reason for denial: \_\_\_\_\_

Check # \_\_\_\_\_ Amount: \_\_\_\_\_ Date: \_\_\_\_\_

Remittance Name: \_\_\_\_\_

Remittance Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Check # \_\_\_\_\_ Date: \_\_\_\_\_

Is entity a charitable organization? \_\_\_\_\_ Yes \_\_\_\_\_ No