## 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:

_____

_____

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** | **TOTAL Maximum Gross Family Income** |
|---|---|
| 1 | $48,560 or less |
| 2 | $65,840 |
| 3 | $83,120 |
| 4 or more | $103,900 |

*In loving memory of Ryan Parsons Linduff*

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

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. Please use a separate sheet for additional information if necessary.

_____

_____

_____

_____

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

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 or fundraisers, on your behalf):

_____

_____

*In loving memory of Ryan Parsons Linduff*

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

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

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:

_____

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 or account number if it appears on the document. PHA requires ALL sources of income from persons in the household.

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

***APPLICATION WIL 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 by 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 _____ Organ Transplant Other treatment:_____

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

Is treatment consecutive requiring them to patient to stay or will they be intermittent where the patient will leave and return? Yes No (please select one) ***A 5 consecutive day stay is required to be eligible for funding***

Name of destination treatment center: _____

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