Application For Hugs and Kisses, Inc. Financial Support

Hugs and Kisses, Inc. offers financial assistance to cancer patients who are in dire need – regardless of the type of cancer. These documents enable us to verify your active creditor accounts as fast as possible so qualifying patients can be assisted as soon as possible. Please be sure to read thoroughly and answer completely to receive assistance without delay.

Hugs and Kisses, Inc. makes every effort to provide as much financial support as possible, but may be limited by the amount of donations received at the time you need support. We suggest you (or someone on your behalf) also seek additional resources of further financial support.

Should it be determined that donations from a region are too limited to supply the adequate support you need, our staff will work with a qualifying patient's family or friends to raise funds for you through a local fund-raiser.

In the pages that follow, please answer all questions thoroughly and supply the requested supporting documents as soon as possible to enable prompt payment of living expenses.

Please read each item below and initial each line to acknowledge you understand and accept our support program:

☐ I understand that Hugs and Kisses, Inc. pays for everyday living expenses only – including co-payments and health insurance premiums – but surgeries themselves and medical procedures are not included.

☐ I understand that all Hugs and Kisses, Inc. financial support is via direct payments to verified creditors.

☐ I understand and agree that I must release medical and financial information to facilitate this application.

☐ I understand Hugs and Kisses, Inc. is bound by the same privacy laws as are medical practitioners and creditors who provide the information I agree to release.

☐ I have read and accept the criteria detailed on the following page that Hugs and Kisses, Inc. Disbursements Committee uses to determine my eligibility for their financial support. And I accept that falsifying information removes me from consideration for Hugs and Kisses, Inc. financial support.

Please mail your completed application and all supporting documents to:

HUGS AND KISSES, INC.
9314 Forest Hill Boulevard, #103
Wellington, FL 33411
ATTN: Disbursements Committee

Criteria

Hugs and Kisses, Inc. publishes that it supports patients in local regions from which donations originate. Though a patient may qualify as described herein, donations from candidates' regions may be insufficient to support every patient in need.

Hugs and Kisses, Inc. also seeks grants to supplement the donations it receives to further assist patients when funds are insufficient. However, grantors have specific rules for use of funds and expect reporting to maintain the integrity of the use of these funds.

Therefore, the criteria defined on this page apply to funds raised via Hugs and Kisses, Inc. events. And should the discussion with a patient reveal that a family is a candidate for funds acquired through a grant to Hugs and Kisses, Inc., a separate list of criteria for a relevant grant may also be required as an addendum to this application.

Hugs and Kisses, Inc. criteria for financial assistance:

- Applicant or family member of applicant is currently **battling any form of cancer**
- Patient family applying for assistance is **financially independent**
- Patient family can document that it has **insufficient income to meet standard living expenses**. Standard living expenses are limited to
    - food
    - clothing
    - shelter
    - utilities
    - transportation
    - communications
    - co-payments for health care coverage
    - insurance premiums

- Patient family has **no assets nor equity** that can be used or sold to cover urgent living expenses
- Patient families own **no luxury items** that are an excessive drain on finances.

    - Hugs and Kisses, Inc. publishes that funds are used to support patients in a desperate situation. It is not our intention to penalize patients who have acquired wealth. We simply focus our support on patient families whose battle with cancer has ruined them financially.

Addendum 1:_____ **Grantor**: _____

Addendum 2:_____ **Grantor**: _____

Addendum 3:_____ **Grantor**: _____

Addendum 4:_____ **Grantor**: _____

Personal Information

Patient's Name: **Gender: □Male □Female DOB:**

Address:

City: **State:** **Zip:** **SSN:**

Phone: **Cell:** **Work:**

Email:

Marital Status **□Single** **□Married** **□Other**

# of Dependents **# in household** **# Wage earners with whom you live:**

□ Patient resides with contact **□ Patient DOES NOT reside with contact. Enter contact's info:**

Contact Name: **□Spouse □Parent □Child □Sibling □Other**

Address:

City: **State:** **Zip:** **SSN: (if relevant)**

Phone: **Cell:** **Work:**

Email:

Best method to reach contact

Proof of Citizenship (attach): **□ Birth Certificate** **□ Passport**

Health Insurance

□None: **□Medicaid** **□Private** **□Other**

Insurance provided through: **□Employer** **□Spouse's Employer** **□Other:**

If no insurance, was insurance account rescinded as a result of cancer diagnosis? If rescinded for other reason, please briefly explain insurance company's reason:

Employment Status

Head of Household:

When diagnosed: **□ Full Time □Part-Time □Self-Employed □Retired □Unemployed**

After Diagnosis: **□Full Time □Part-Time □Self-Employed □Retired □Unemployed**

Date Head of Household last worked: _____|_____|_____

Spouse

When diagnosed: **□ Full Time □Part-Time □Self-Employed □Retired □Unemployed**

After Diagnosis: **□Full Time □Part-Time □Self-Employed □Retired □Unemployed**

Date spouse last worked: _____|_____|_____

Patient

When diagnosed: **□ Full Time □Part-Time □Self-Employed □Retired □Unemployed**

After Diagnosis: **□Full Time □Part-Time □Self-Employed □Retired □Unemployed**

Date patient last worked:_____|_____|_____

□ N/A (if patient is a minor or dependent)

Others

When diagnosed: **□ Full Time □Part-Time □Self-Employed □Retired □Unemployed**

After Diagnosis: **□Full Time □Part-Time □Self-Employed □Retired □Unemployed**

Date spouse last worked: _____|_____|_____

Describe how treatment is impacting your ability to work / remain employed.

Medical Information

Current Diagnosis: _____

Date Diagnosed: ____ | ____ | ____ **Stage:** ____ **Type (if known)** _____

Are you being treated for recurrence? □Yes □No

To date, my therapy has included:

- □ **Surgery** **Date** ____ | ____ | ____
- □ **Removal of cancerous body** **Date** ____ | ____ | ____
- □ **Chemo therapy** **Date** ____ | ____ | ____
- □ **Radiation** **Date** ____ | ____ | ____
- □ **Gene Therapy** **Date** ____ | ____ | ____

Surgeon Information

	Name	Location	Phone
Surgeon:			
Oncologist:			
Radiation Oncologist:			
Social Worker / Case Manager:			

Other therapy or treatment details

Income – Entire Household

Employer: ______________________________

Address: ______________________________

City: __________ **ST:** ____ **ZIP:** __________ **Hours/week** __________

Phone: ______________________________

Human Resources Contact: ______________________________

Gross Wages (before taxes or deductions): ______________________________

Employer: ______________________________

Address: ______________________________

City: __________ **ST:** ____ **ZIP:** __________ **Hours/week** __________

Phone: ______________________________

Human Resources Contact: ______________________________

Gross Wages (before taxes or deductions): ______________________________

Employer: ______________________________

Address: ______________________________

City: __________ **ST:** ____ **ZIP:** __________ **Hours/week** __________

Phone: ______________________________

Human Resources Contact: ______________________________

Gross Wages (before taxes or deductions): ______________________________

Employer: ______________________________

Address: ______________________________

City: __________ **ST:** ____ **ZIP:** __________ **Hours/week** __________

Phone: ______________________________

Human Resources Contact: ______________________________

Gross Wages (before taxes or deductions): ______________________________

Expenses

Please list creditors' phone numbers and account numbers so we may verify and pay accounts directly. Please return with your application with a copy of creditors' most recent statements. If your application meets our Disbursements Committee criteria, you will be asked to submit financial statements. Please be prepared to send bank statements and tax returns should we need to request them of you.

Creditor	Account #	Balance Due	Date Due

I understand that Hugs and Kisses, Inc. promotes that its financial support remains local to the regions from which funds are raised and that the Hugs and Kisses, Inc. Disbursements Committee evaluates many cases and awards financial support to those patients who are in the most immediate need. By signing below, I verify that all information provided regarding my condition, income, and expenses are true. I release Hugs and Kisses, Inc. from all liabilities and claims that may arise from the donation of money and/or services provided. I hereby authorize Hugs and Kisses, Inc. to contact my doctors, creditors and related agencies to verify what I've entered to evaluate my need for financial assistance.

Signed: _____ Date: _____

Print: _____