Gayl's Legacy Fund Assistance Application

Information About Gayl's Legacy Fund Assistance Program:

- *Gayl's Legacy Fund* provides financial assistance with rent/mortgage, electricity/gas, water, phone, auto loans, health and auto insurance for up to **3 months**.
- All properly completed *Assistance Applications* will be reviewed within 30 days, and Pink Door will notify you in writing if your application/financial request is granted.
- All monies will be mailed directly to the creditors. No payments are made directly to an applicant.
- Pink Door cannot assist with reimbursements for bills already paid through bank withdrawal or credit card.
- ***Please understand that we are not an emergency fund and <u>cannot</u> provide immediate assistance. All decisions are made on a quarterly basis.***
- Pink Door does not discriminate and will consider all submitted applications fairly and equally.
- A submitted application is not a guarantee of receiving financial assistance. Funds are limited, and based on eligibility and availability.
- All application information is held strictly confidential.
- All qualifications listed above for *Gayl's Legacy Fund Assistance Program* must be met in order to be eligible.

APPLICANT MUST FULLY COMPLETE THE GAYL'S LEGACY ASSISTANCE APPLICATION AND PROVIDE ALL REQUIRED DOCUMENTS TO BE CONSIDERED.

<u>YOU QUALIFY for the Gayl's Legacy Fund Assistance Program if:</u>

- You are a woman in active cancer treatment and at least 18 years of age.
- You live in Houston or surrounding counties. (Harris, Montgomery, Waller, Fort Bend, Brazoria, Galveston, Chambers or Liberty counties)
- You are currently employed either part or full-time, or on leave of absence due to illness.

<u>YOU DO NOT QUALIFY for Gayl's Legacy Fund Assistance Program if:</u>

- You were unemployed at the time of your cancer diagnosis.
- You are currently receiving monthly financial aid through the State and/or Social Security Disability Insurance Benefits (SSDIB) totaling more than $1,500.
- You have received support from Pink Door within the last twelve months.

APPLICANT MUST FULLY COMPLETE THE GAYL'S LEGACY ASSISTANCE APPLICATION AND PROVIDE ALL REQUIRED DOCUMENTS TO BE CONSIDERED.

After Completing Paper Application: Make a copy of the application for your records. Mail **<u>original</u>** application and all necessary documentation to **Pink Door, Post Office Box 6990, Houston, TX 77265.**

For questions/additional information: Contact Pink Door at grants@pinkdoornonprofit.org or 832-727-3121.

Gayl's Legacy Application Checklist

Please use this checklist as a guide and easy reference as you prepare documents and information to complete the online or mailed grant application process. We encourage you to keep this list along with a copy of your completed application for your records.

FOR YOUR APPLICATION TO BE CONSIDERED, ALL REQUESTED FORMS AND ATTACHMENTS MUST BE ENCLOSED.

- ☐ PERSONAL INFORMATION FORM (page 3)
- ☐ Provide proof of your total household income for two consecutive months (copies of your paycheck stub, disability and/or retirement)
- ☐ PATIENT STATUS FORM (PAGE 4)
- ☐ Must provide a letter (on letterhead) from your health care provider, nurse, social worker or nurse navigator stating your current health status and type of cancer.
- ☐ FUNDING REQUEST INFORMATION (page 5)
- ☐ Attach current copies of the bills/statements that you would like Pink Door's assistance to cover.
- ☐ ASSISTANCE QUESTIONNAIRE (page 6)
- ☐ Sign PROGRAM TERMS AND CONDITIONS (page 7)

PERSONAL INFORMATION

First Name: _____ Middle Initial: ____ Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

County: _____ Date of Birth: _____/_____/_____ Age: _____

Ethnicity(*required for state and local grant funding):_____

Primary Phone: _____ Alternate Phone: _____

E-mail address: _____

Alternate Contact
Name:_____Relationship:_____

Alternate Contact
Email: _____ Phone: _____

Marital Status (circle one): Single Married Divorced Widowed Partnered

Employment Status ***before*** your cancer diagnosis: (please circle one)
Full-time Part-time Self-Employed Unemployed Government Assistance

Employment Status ***currently***: (please circle one)
Full-time Part-time Self-Employed Disability/sick leave Unemployed Govt. Assistance
***** *Please provide* copy of driver's license, birth certificate, or passport.**

HOUSEHOLD INCOME INFORMATION

Occupation:_____

Number Wage Earners in Household: _____ Total Number Living in Household: _____

Do You: ____ Rent/Lease ____ Own Home _____ Live with Family Member or Friend

Number and Age of Dependents in Household: _____

Gross Monthly Salary: $_____ Gross Monthly Disability: $_____

Other Income: _____
****** Please provide copies of paycheck stubs and any other income for 2 consecutive months.***

HEALTH INSURANCE (circle one)

None Medicare Medicaid Supplied by Employer/Spouse Employer Private

PATIENT STATUS

Cancer type:_____Stage/Grade: _____

Doctor's Name: _____Phone: _____

Hospital: _____

Social Worker or Patient Navigator's Information:

Name: _____Phone: _____

Email: _____

*****Please provide a letter (on letterhead) from your health care provider. Either your physician, nurse, social worker or nurse navigator will suffice, stating your current health status and type of cancer.**

FUNDING REQUEST INFORMATION

Please provide the copies of all bills requested, name of the billing company, the address payment should be sent to and the monthly amount.

BILL COMPANY NAME	SEND PAYMENT TO	MONTHLY AMOUNT
Mortgage/Rent		
Electricity		
Gas		
Water		
Phone		
Auto Loan		
Auto Insurance		
Health Insurance		
Other Requests		

PLEASE NOTE:

- **All monies will be mailed directly to the service providers. No payments are made directly to an applicant.**
- **Pink Door cannot assist with reimbursements for bills already paid through bank withdrawal or credit card payments.**
- ***Please understand that we are not an emergency fund and cannot provide immediate assistance.*** **All decisions are made on a quarterly basis.**

ASSISTANCE QUESTIONNAIRE

Why is financial assistance from Pink Door important to you?

If you are requesting financial assistance for anything other than household bills, what do you need and why do you need it?

Is there any additional information you would like to add about yourself/current situation?
(You may attach an additional page if needed.)

How did you hear about the *Gayl's Legacy Fund Assistance Program* (please be specific and include names)?

- ☐ Physician _____
- ☐ Nurse navigator_____
- ☐ Social worker_____
- ☐ Hospital_____
- ☐ Internet_____
- ☐ Other_____

PROGRAM TERMS AND CONDITIONS:

1. Allocation of Funds to the *Gayl's Legacy Assistance Program*. Pink Door's Executive Board of Directors allocates certain monies and other resources to the *Gayl's Legacy Fund Assistance Program* through its approval of Pink Door's annual budget. The number and size of requests granted by Pink Door is dependent upon the allocation of Pink Door resources to the *Gayl's Legacy Fund Assistance Program* within Pink Door's annual budget. Pink Door's Executive Board of Directors has exclusive determination as to those monies and resources made available to the *Gayl's Legacy Fund Assistance Program*. Any restricted gifts made in the name of the *Gayl's Legacy Fund* will also be allocated to the program as agreed upon by the donor and Pink Door.

2. Selection Process: Pink Door's Program Committee manages the *Gayl's Legacy Fund Assistance Program's* application and selection process, including the actual selection of the awarded applicants. The Program Committee meets throughout the year to consider all completed and qualifying applications received to select successful applicants. Pink Door and its Program Committee reserve the right to not grant a request, or partially grant a request based upon the allocation of funds to the *Gayl's Legacy Fund Assistance Program*, the qualifications and needs of the other applications considered, and the available resources of Pink Door. **THIS APPLICATION DOES NOT CONSTITUTE ANY PROMISE OR ASSURANCE BY PINK DOOR (OR ANY OF ITS REPRESENTATIVES) TO AN APPLICANT REGARDING THE GRANTING OF THEIR REQUEST.** Any request actually granted will be specifically delineated in a *Gayl's Legacy Fund Assistance Program* Acceptance Form provided to the successful applicant upon the Program Committee's duly approving such request.

3. Grants of Rights, Restrictions on Use: The information provided by applicant herein will only be utilized for Pink Door's consideration of awarding funds through the *Gayl's Legacy Fund Assistance Program*. Your information will not be shared with anyone unaffiliated with Pink Door. Should your request be granted, Pink Door will not communicate with any third parties relating to your request without your prior consent. Pink Door reserves the right to utilize your *Gayl's Legacy Fund Assistance Program* experience, first name and possible photo to share with potential sponsors as well as the general public in order to promote Pink Door's *Gayl's Legacy Fund Assistance Program* to other women cancer survivors that could potentially participate in this program. Pink Door reserves the right to terminate *Gayl's Legacy Fund Assistance Program* at any time due to budget restraints or any unforeseeable obstacle.

I affirm that I have read the all of the above important information, and attest that the information provided by me in this application is true and correct to best of my knowledge.

Applicant's Signature: _____

Printed Name: _____ Date Signed: _____

Mail <u>original</u> application to: **Pink Door**
Post Office Box 6990
Houston, TX 77265