



# ANSWERS FOR ANGELS' GRANT APPLICATION

## For Child, Adult or Immediate Family Financial Support

### Funding Request Guidelines

- Cancer patient or their immediate family member must complete this application IN FULL.
- 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.
- Financial support is a grant for which Answers for Angels pays the provider directly or provides a gift card for the service. No cash grants are given.
- You may apply multiple times until you receive the lifetime grant of \$350.
- Attach applicable bill(s)/documents --Answers for Angels' Board Members and/or Review Committee may request other documents upon review of this application.
- Email/Mail completed application to [KatieDavis@AnswersForAngels.com](mailto:KatieDavis@AnswersForAngels.com) or Answers for Angels, Review Committee, 21201 S. Elsner Road, #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 activities, classes, and consultations listed below, are to promote physical, mental, and emotional health to balance the mind, body, and spirit. In addition, any bill in child's, adult's, or immediate family members' name are funded or Gift Cards given. Please check all that apply. If questions, please call Katie Davis at 815/600-3215 and leave a message.

<input type="checkbox"/> Airplane Ticket, Hotel Room, Gas Cards	<input type="checkbox"/> Art, Drawing, & Other Classes
<input type="checkbox"/> Bills, any, with patient's name on it; i.e. medical, electrical, gas, phone, etc.	<input type="checkbox"/> Chiropractic Adjustments
<input type="checkbox"/> Consult w/Integrative Oncologist/Practitioner	<input type="checkbox"/> Cooking Healthy Recipes/Gardening Class
<input type="checkbox"/> Fishing License	<input type="checkbox"/> Gift Cards from Stores (Please specify)
<input type="checkbox"/> Gym Membership	<input type="checkbox"/> Meditation/Yoga Classes
<input type="checkbox"/> Oncology Acupuncture	<input type="checkbox"/> Oncology Massage Gift Card
<input type="checkbox"/> Other (please describe)	<input type="checkbox"/>

Describe Circumstances for Need (narrative): attach additional sheet if necessary

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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: \_\_\_\_\_