THE JOURNEY FUND

2023 EMERGENCY ASSISTANCE APPLICATION

APPLICANT INFORMATION:

Name: _____ DOB: _____ Today's Date:_____

Address: _____

Phone: _____ E-mail: _____

If applicant is a minor, Parent/Guardian Name and Phone: _____

☐ Female ☐ Male ☐ Other English Speaking? □ Yes □ No, language:_____

Ethnicity: ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other _____

Annual Household Income: _____ Household Size: _____

Primary Cancer: _____ Stage: _____

Residence City: _____ Treatment City: _____

Please explain why you feel that assistance should be granted to you and why it's medically necessary (attach separate sheet if needed):

_____

_____

_____

☐ I give permission for my healthcare representative to release the information disclosed herein to The Journey Fund.

☐ I give The Journey Fund permission to communicate with my healthcare representative regarding this application.

☐ I understand this grant amount will be determined by The Journey Fund.

☐ I give my permission for my photographs, quotes or videotape images to be used for publicity in publications or other media formatted.
Please initial _____

☐ I would like to be considered for The Journey Assistance Program Application

Applicant Signature: _____

HEALTHCARE REPRESENTATIVE INFORMATION:

Name: _____ Phone: _____

Facility Name: _____ E-mail: _____

☐ I have verified that this patient is in active treatment.

☐ I have exhausted all other resources in efforts to find assistance for applicant.

Healthcare Representative Signature: _____

*** Please note, your application will be reviewed within 30 days of submission date. Submit the completed application to: akelson@nwmsonline.com**

CRITERIA FOR EMERGENCY ASSISTANCE APPLICATIONS

1. Applicant is in active treatment.

2. Applicant is a South Puget Sound resident or is receiving treatment at a facility located in South Puget Sound.

3. Applicant is **financially eligible,** as defined below, OR the request is for a service and/or product that is **medically necessary,** as defined below**.**
    1. An applicant is financially eligible if he or she receives an annual income, after taxes, of 250% or less of the current federally established poverty level. Annual income includes both earned income and unearned income (public assistance, investment etc.) *Please see chart below.*
    2. A service or product is "medically necessary" if it directly contributes to cancer-related diagnosis, treatment, or recovery.

4. Applicant has exhausted all other resources.

5. Applicant has not exceeded the limits, as defined below, for emergency assistance.
    1. An applicant is limited to receiving Emergency Assistance once every 12 months. The amount received may not exceed $350 in any 12-month period.

Federal Poverty Guidelines

Persons in Family/Household	Annual Income (250% of FPG)	Monthly Income (250% of FPG)
1	$33,975	$2,831
2	$45,775	$3,815
3	$57,575	$4,798
4	$69,375	$5,781
5	$81,175	$6,765
6	$92,975	$7,748
7	$104,775	$8,731
8	$116,575	$9,715

For family units with more than 8 members, add $11,800 annually ($983 months) for each additional member to meet the 250% of federal poverty guidelines.