



Our Financial Assistance Process

The Meggs Foundation is currently working exclusively with Levine Cancer Institute and its Patient Navigators to identify qualified candidates for our program.

We will provide direct financial assistance to young adults (20-39 years old) in Charlotte who are currently undergoing cancer treatment and are having difficulty making day-to-day living expenses as a result of their treatment. Qualified candidates need to make a clear and direct connection between current financial difficulties and the onset of medical treatment (e.g. lost wages, high medical bills, limited ability to work because of side effects).

The procedure for providing grants will be determined as an ongoing process tailored to current circumstances and conditions. Our Fall 2021 application period is from November 1-30. We expect that average grant size will be \$1,500-\$3,000.

Funding is not provided for medical bill payments, but we will support approved applicants by relieving some of their immediate financial concerns for a wide variety of day-to-day living expenses that will help mitigate the financial burden of your treatment. These categories include:

- Rent/Mortgage Supplementation
- Basic utilities including water, sewer or electricity
- Phone (phone bills that include cable or internet will not be considered)
- Special equipment or supplies
- Transportation vouchers for treatment
- Car payments/repair
- Travel and lodging for second opinions

Payments will not be made directly to patients, but will be made directly on behalf of patients to respective third parties in the categories above.

General Eligibility for Financial Assistance:

Citizenship Status	Applicant must be a U.S. citizen and North Carolina resident.
Age	Applicant must be 18-39 Years Old and not living with a parent
Financial Status	Applicant must be financially independent from a tax perspective

Treatment Status

- Must Be Currently Undergoing Treatment (Chemotherapy, Surgery, Radiation).
- Must have written verification of ongoing treatment from an oncologist or medical doctor.

Employment Status

- Employed, but treatment schedule prevents full-time
- Disabled or on short-term disability
- Part-time while going to school

Application Requirements

- Applicants must fully complete and sign the Financial Assistance Application and Consent to Release Information & Information. The application includes requests for supporting financial information. Applications cannot be submitted for Foundation Advisory Board review until **all** required documents are received.
- **There is no guarantee that a submitted application will result in a grant.** Patients may apply more than once, but no more than twice in any given calendar year.
- Approval of the application is required by the Foundation Advisory Board based on review of the applicant's information and is at the discretion of the Advisory Board only. The Foundation Advisory Board sets the eligibility criteria and has final determination in all cases.
- **We fully respect the privacy of each applicant. All information gathered through grant applications will be kept confidential.**
- An email address or cell phone number is required to communicate with The Meggs Foundation. We will send notification within 4-6 weeks of receipt of your application as to approval or denial.

Post Application

- Upon approval, The Meggs Foundation will work with the applicant to determine which bills will be paid and on what timeline. Billing statements must be submitted via the Foundation's email (info@themeggsfoundation.org) to be eligible for payment.
- The financial assistance program is designed as a one-time use benefit, with any exceptions requiring full Board approval.
- While not necessary to secure a grant, we would greatly appreciate your willingness to share with The Meggs Foundation the impact that our grants have had on your ability to deal with the financial obstacles and stress during your medical treatment process.

Financial Assistance Application
MUST BE A U.S. CITIZEN TO APPLY

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Age: _____ Number of Children (under 20 years old): _____

Ethnicity (optional): _____ Marital Status (optional): _____

Date of Diagnosis: _____ Diagnosis: _____

Oncologist: _____ May we contact your oncologist? _____

Are you currently undergoing active treatment (surgery, chemotherapy, and/or radiation)? _____

Please describe your treatment plan (surgery, chemotherapy, and/or radiation): _____

Length of treatment (include specific dates and timeframe): _____

Treatment Facility: _____ Insurance Provider: _____

Monthly Income:

Monthly Net Earnings (self & spouse): \$ _____ Past 12 Months Earnings (self & spouse): \$ _____

Other Income (Explain: _____

(child support, alimony, rental income, 401k, etc.)

Do you own property other than you primary residence? _____

Checking Account: \$ _____ Savings Account: \$ _____

Have you received assistance in the past 12 months from other charitable organizations, churches, etc?

If yes, total amount received: \$ _____ From Whom? _____

TOTAL NET MONTHLY HOUSEHOLD INCOME: \$ _____

Monthly Expenses:

Rent/Mortgage Payment: \$ _____ Phone: \$ _____ Cable: \$ _____

Electric/Gas: \$ _____ Water/Sewer: \$ _____ Food: \$ _____

Auto Payment: \$ _____ Automobile Fuel: \$ _____ Auto Ins: \$ _____

Property Ins.: \$ _____ Property Tax: \$ _____ Health Insurance: \$ _____

Life Insurance: \$ _____ Other Medical Expenses: _____

Other Expenses (List): _____

(child support, alimony, church tithes, etc.)

TOTAL MONTHLY EXPENSES: \$ _____

Employment:

Are you currently working (circle one)? Yes / No / Retired / Disabled

If not currently working, describe reason: _____

Employer: _____

Employer Address: _____ Phone: _____

Short-Term Disability (circle one): Applied / Receiving / Not Applicable

Other Information:

What is your Primary financial need right now (select one)?

- a. Mortgage/Rent Assistance
- b. Utilities Assistance
- c. Transportation Assistance
- d. Groceries/Necessities Assistance
- e. Other: _____

Please describe your request for assistance with household bills in detail and outline your need (include amounts of any past due bills). Medical bills are not an expense covered through The Meggs Foundation:

Please describe how the onset of your medical treatment has impacted your ability to pay your bills – lost wages, limited ability to work, poor insurance coverage, etc.:

Please list your name if you are filling out this application on behalf of applicant: _____

State your relationship to the applicant and contact info: _____

How did you hear about The Meggs Foundation? _____

Assistance Request / Applicant Statement / Release / Affirmation

I do agree to release to The Meggs Foundation II, Inc. ("The Meggs Foundation") or its duly authorized representative, any information deemed necessary to complete its investigation of my application for financial assistance and as may be reasonably required to assist myself and my family. As an inducement to The Meggs Foundation to consider supplemental financial support in conjunction with the medical treatment of the applicant named above the undersigned does hereby affirm as follows:

1. The term "non-medical expenses" is understood to mean those reasonable and necessary expenses incurred by the family of the above-named Applicant or the above-named Applicant, in conjunction with that Applicant receiving medical treatment. Financial assistance will be provided, with the use of said funds to be specified by the Meggs Foundation. Bills cannot be in another person's name or be on an automatic payment system with creditor.
2. The undersigned acknowledges(s) and agree(s) to maintain records that will be made available to The Meggs Foundation upon reasonable request, detailing the expenditures made from the funds provided by the organization.
3. **If my application is approved for further review by The Meggs Foundation, I will provide supporting documents for assistance requested such as.**

- Copy of driver's license or state identification card;
- Proof of patient eligibility; a letter of support from doctor, nurse or social worker;
- Copy of bills to be paid (please submit photocopy of invoice to ensure grant payment attributed to the correct account);
- Photocopy of Bank statements from all adults residing in household (3 months);
- Photocopy of most recent Federal Income Tax Return and W2 for all members of the household of working age;
- Photocopy of last pay stub;
- Any other applicable income for each individual living in the household including copies of statements for 401k's, IRA's, HSA's, HRA's, FSA's, stocks, bonds and any other, if they exist; and
- Photocopies of current rental agreement or Lease.

*Payments made for patients may require an IRS form W-9 to be completed by The Meggs Foundation.

The Meggs Foundation will pursue restitution for grants if it is determined that the information submitted on the application is false.

I have read the guidelines for financial assistance and I declare that the information furnished on this application form, including attached sheets, is true and correct to the best of my knowledge.

For good consideration which I acknowledge, I irrevocably grant to The Meggs Foundation II, Inc., ("The Meggs Foundation") and/or its subsidiaries, affiliates, representatives, assigns, licensees, and/or successors the right to use my story, my name, artwork, photographs, audiotapes, and/or letters that I provide of my child, my family, or myself in publications, slides, videotapes, motion pictures or on the internet, and in all forms and media including composite or modified representations for all purposes, including advertising, charitable solicitations, trade, or any commercial and/or charitable purpose throughout the world and in perpetuity. I waive the right to inspect or approve versions of any of the above listed used for publication or the written copy that may be used in connection with any images. The Meggs Foundation is permitted, although not obligated, to include my name as a credit in connection



with any images. I understand any visual images, story, letters or recordings may be primarily used to inform families, volunteers, donors, the media and general public about The Meggs Foundation programs, services, fundraising efforts, or events. I gladly give this authorization to support the efforts of The Meggs Foundation. I understand this authorization shall continue unless terminated in writing by The Meggs Foundation. I release The Meggs Foundation and The Meggs Foundation's subsidiaries, affiliates, assigns, licensees, directors and successors from any claims that may arise regarding the use of my image, including any claims of defamation, invasion of privacy, or infringement of moral rights, rights of publicity, or copyright. The Meggs Foundation is not obligated to utilize any of the rights granted in this Agreement. Applicant's Name Date Signature

Dated this ____ day of _____, in the year _____

Applicant Signature

Please Print Name