MJ's Gift Financial Assistance Program

The MJ's Gift Financial Assistance Program is implemented by Below The Belt Women's Cancer Outreach and dedicated to supporting women on Cape Cod with gynecologic cancers by helping with medical and daily living expenses during and immediately after cancer treatment.

Grants may be given to qualified applicants in the amount of $1,000 per year for such things as:**

- Medical expenses
- Prescriptions
- Rent or mortgage payment
- Utility bills
- Car payment
- Car insurance
- Health insurance deductibles
- Psychiatrist visits

To Qualify for Assistance: (Submission of an application in not a guarantee of assistance)

Gynecologic cancer patients who meet the following residency, medical and financial qualifications may submit an application for consideration.

Residency: (Proof of Cape Cod residency is required with the application.)

Medical:

1. Diagnosis of a gynecologic cancer

2. Currently receiving treatment (e.g. chemotherapy, radiation therapy, surgery, PARP-inhibitor) or completed treatment for a gynecologic cancer within the last three months.

Financial:

1. Your monthly household expenses must be more than your monthly household income (defined as income received from patient and their domestic partner, regardless of gender), and your total household income must be less than or equal to 300% of the HHS Federal Poverty Level. In addition, we may be checking to see if your household income is equal to or less than the Area Median Income for your county.

2. Your available assets, including cash, investments, and real estate properties other than your home, are less than the total of 6 months of your household expenses during treatment.

You may be asked to provide additional paperwork in order to verify your qualifications. If any misleading or false information is submitted in writing or by phone, BTBWCO has the right to withdraw your application, stop all assistance and take steps to recover previous awards.

Follow these steps below to apply for assistance.

Step 1: Fill out the MJ's Gift Application pages 1 – 4.

Step 2: Have your oncologist's office complete the Medical Verification form on page 5 which can be returned with your completed application or the office may send it in separately.

Step 3: Make a copy of your current Massachusetts Driver 's License, Massachusetts issued I.D. or other proof of residency with an address matching your application (e.g. utility bill, etc.) and include with your application.

Step 4: Mail your completed application** and all required attachments to:
Below The Belt
55 Thankful Ln.
Cotuit, MA 02635

*For quicker processing, email the application to *diane@belowthebelt.org*

Once we receive your application, the MJ's Gift committee will review it and send you an Agreement or Decline letter by mail or email. If your application has been accepted, you will be contacted to determine how to proceed with bill payment.

This is also a time to ask questions and clarify any issues. Applications are processed in as timely a manner as possible. For questions, contact: Diane Riche at 508-827-1212 or email *diane@belowthebelt.org*

Please be sure to provide all the information requested here.

An incomplete application will delay our ability to provide you with assistance.

MJ's GIFT FINANCIAL ASSISTANCE PROGRAM

Personal Information

Last Name_____ First Name_____ Middle Initial_____

Address_____ City_____ State_____ Zip_____

Date of Birth _____ Email address_____

Phone: Home _____ Mobile_____ Work _____

Best way to reach you: (circle one) Home Phone Cell Phone Work Phone Email

Best time to reach you: (circle one) Morning Afternoon Evening Best hours:_____

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

Additional Contact Person:

Name_____ Relationship_____ Phone_____

Email_____ Do you have health insurance? ____Yes ____No

(check all that apply) ____Private insurance ____Medicare ____Medicaid ____ VA ____ Other

If private insurance, please name insurance company _____

Comments: _____

Are you currently working? ____Yes ____No If yes, how many hours per week? _____

Were you working before your cancer diagnosis? ____Yes ____No

Total # in household_____ # of wage-earners in home_____ # of dependents_____

Who referred you?_____ Referring person's phone_____

Referring person's email_____

Have you received MJ's Gift before? ____Yes ____ No If yes, what year?_____

Are you participating in the Woman to Woman peer support program? ____Yes ____No

Name: _____

MJ's Gift Application / Income Information

(Note: We may ask you to provide us with a copy of your most recent Federal Income Tax Return.)

Monthly Wages

Your monthly wages after payroll taxes $_____
Spouse or partner's monthly wages after payroll taxes $_____
Other monthly income from wages or self-employment $_____

Monthly Income from Benefits & Insurance

Employer disability insurance $_____
Unemployment insurance $_____
Retirement / Pension $_____
401K / IRA income $_____
Social Security $_____
SSI / SSDI $_____
Other benefits/Insurance $_____
Income from assistance alimony / Child support received $_____
Low-Income Energy Assistance Program (LEAP) $_____
Food Stamps (SNAP) $_____
Temporary Aid to Needy Families (TANF) $_____
Aid to the Needy and Disabled (AND) $_____
Section 8 from HUD (housing supplement) $_____
Help from family members $_____
Help from religious / faith community $_____
Help from friends $_____
Help from other nonprofit organizations $_____
Other Assistance $_____

Assets		Monthly Income from Assets
Cash / Checking Value:	_____	$_____
Savings Value:	_____	$_____
Life insurance value:	_____	$_____
Investments value:	_____	$_____
Real estate value: (Not the house you live in)	_____	$_____

TOTAL CURRENT MONTHLY INCOME: $_____
(Please total all monthly income listed above.)

Name: _____

MJ's Gift Application / Expenses Information

Monthly Household Expenses

Rent $_____
Mortgage $_____
Energy bill $_____
Water bill $_____
TV / Internet / Cable / Satellite $_____
Telephone / Cell (including long distance) $_____
Food $_____

Monthly Dependent Expenses

Child care $_____
Child support paid $_____
Elder care $_____

Monthly Transportation Expenses

Car payment $_____
Gasoline$_____
Car insurance $_____
Parking / Public transportation $_____

Monthly Medical Expenses

Health insurance premiums$_____
Medical costs (after Insurance) $_____
Medication costs (after insurance) $_____

Monthly Loan Expenses

Loan payments $_____
Credit card payments $_____

Other Expenses

Other:_____ $_____
Other:_____ $_____
Other:_____ $_____

TOTAL CURRENT MONTHLY EXPENSES: $_____
(Please total all monthly expenses listed above.)

If you currently seeking any other assistance for outstanding expense payments, please explain:

_____

Name: _____

MJ's Gift Application / Gynecologic Cancer History

Date Diagnosed_____ Type of Gynecologic Cancer_____ Stage_____

Have you experienced a recurrence? _____ Have you seen a Gynecologic Oncologist?_____

Have you participated in a clinical trial?_____ Treatment Facility_____

Surgeon _____ Oncologist _____

Social Worker_____ Nurse / Navigator_____

Please check your reason for applying for financial assistance:

_____ To help pay an annual health insurance deductible
_____ To help pay for a prescription
_____ To help pay for a psychiatrist
_____ To help pay for other medical expenses
_____ To help pay housing expenses (rent or mortgage)
_____ To help pay for utilities
_____ To help pay for car payments

Read and check the lines to verify the following information:

____I have read Page 1 and understand how and who MJ's Gift helps with financial assistance.
____I live on Cape Cod
____I am participating in the Woman to Woman peer support program.
____I have enclosed proof of residency.
____I am currently undergoing chemotherapy or other oncologist-directed treatment for gyn cancer.
____I am currently within three months of gynecologic cancer-related surgery, chemotherapy, or oncologist-directed treatment.
____I have signed the bottom of this page, which serves as a medical release giving BTBWCA permission to obtain the necessary medical information to process my application.
____I understand that BTBWCO will ask personal questions about my treatment and financial status. I agree to provide accurate answers in a telephone or in-person interview.
____I understand that BTBWCO provides services that are free and that all awards are made at its sole discretion. The information provided in this application is true. I release BTBWCA from all liabilities or claims whatsoever arising out of the donation of money and/or services provided. I authorize BTBWCO to release any information including my name, address, and type of assistance provided to any other social service agency at BTBWCO discretion. I also authorize the release of any medical information and documentation required by BTBWCO for the purpose of verifying this application, and I agree to sign any additional authorizations that may be required.

Applicant's Signature_____Print Name_____Date: _____

Healthcare Provider: Please complete and mail or email. Thank you for your assistance.

Mail:
Below The Belt Women's Cancer Outreach
55 Thankful Ln.
Cotuit, MA 02635

Email: diane@belowthebelt.org

Phone: 508-827-1212

Medical Verification

Patient name _____ Confirmed diagnosis_____

Date of initial diagnosis _____Stage_____ Cell type_____ Grade_____

Patient is currently seeing a Gynecologic Oncologist ____Yes ____No Name _____

Patient is currently seeing a Medical Oncologist ____Yes____ No Name _____

Patient is currently being treated for a recurrence ____Yes____No Recurrence date_____

Patient has undergone surgery ____Yes ____No Most recent surgery date _____

Patient has a planned surgery ____Yes ____No Planned surgery date _____

Surgical procedure _____

Patient is currently undergoing chemotherapy ____Yes ____No

Chemotherapy start date_____ Anticipated end date_____

Drug _____ Drug _____

Patient is currently undergoing radiation therapy ____Yes ____No Dates_____

Patient is being admitted to a clinical drug trial ____Yes ____No

Clinical trial start date _____ Anticipated end date_____

Other planned treatment(s) or important medical information about this patient's gynecologic cancer treatment_____

Referring licensed professional completing this form: (MD, DO, PA, NP, RN, RN or LCSW)

Name & Credentials _____ Hospital/Clinic _____

Address _____ City _____

State _____Zip_____Phone ( )_____Email_____

My signature below affirms the diagnosis and treatment information as described on this page.

Referring professional signature_____ Date _____