THE ATRIUM FOUNDATION
Assistance Application

This form is to request assistance from The Atrium Foundation (TAF), a nonprofit foundation provides financial support to people affected by cancer.
Information about TAF can be found at https://theatriumfoundation.org.

The applicant must meet the eligibility requirements and submit a completed signed application. Please note TAF may ask for a signed medical summary from the applicant's oncologist.

TAF may not be able to provide assistance to all applicants, it will communicate decisions directly to the applicant. If TAF is unable to provide assistance it will do its best to provide references to other potential resources.

Eligibility Criteria:

Applicant is a Cancer Patient or the Parent/Guardian or Caregiver of a Cancer patient who meets all of the below -

1. Individual Adjusted Gross Income of $70,000 or less per year or a Household Adjusted Gross Income of $120,000 or less per year.
2. Patient has a cancer diagnosis and is planning to start or is going through active cancer treatment. Treatment means the applicant has an upcoming clinical trial, surgery, chemotherapy, or radiation plan or session to treat cancer OR
   a. Applicant has had a cancer diagnosis and needs assistance post care or end of life expenses
3. Experiencing a financial hardship as a direct result of their cancer diagnosis or treatment.
4. The Applicant must agree to meet, virtually or in-person, with members of the TAF Team for an pre-approval interview.

Submission Instructions:

1. Applicant must email completed application to support@theatriumfoundation.org

For Questions, contact The Atrium Foundation at (512) 522-1813 or via email support@theatriumfoundation.org

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SECTION I – PATIENT INFORMATION

APPLICANT NAME

PATIENT NAME, if different from Applicant Name

PARENT/GUARDIAN/CARE-GIVER of PATIENT, if applicable

Designation (Circle One): PARENT GUARDIAN CARE-GIVER

ADDRESS

CITY	STATE, ZIP CODE
PHONE	EMAIL
DATE OF BIRTH	# OF CHILDREN / AGES, if applicable
ONCOLOGIST & TREATMENT CENTER NAME	ONCOLOGIST & TREATMENT CENTER NAME PHONE
SOCIAL WORKER NAME, if applicable	SOCIAL WORKER PHONE, if applicable

DETAIL ASSISTANCE NEEDED

Type of expense (Circle One): Medical Living Mental Health & Wellness End of Life

Cost of Expense:

Detail of Expense:

**Please note that credit card payments are outside of TAF policy*

How did you find The Atrium Foundation? *(social media, web search, referral? If referral, by who?)*

Would you like to be showcased on The Atrium Foundation Website as one of our Beneficiaries? YES or NO

Would you like to be showcased on The Atrium Foundation's Social Media as one of our Beneficiaries? YES or NO

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SECTION II – MEDICAL HISTORY	
DIAGNOSIS	
STAGE	GRADE
DATE OF DIAGNOSIS	DATE OF LAST APPOINTMENT
SURGERY (SPECIFY TYPE)	DATE OF PROCEDURE & EXPECTED RECOVERY TIME
CHEMOTHERAPY	START DATE & EXPECTED END DATE
RADIATION	START DATE & EXPECTED END DATE
CURRENT PROGNOSIS	
ADDITIONAL COMMENTS	

SECTION III – APPLICANT CONSENT

Policies & Procedures:

1. TAF does not reimburse for bills already paid.
2. TAF must be given the most recent statement(s) prior to paying a bill(s)
   - TAF will verify the amount due prior to paying bill(s).
   - Payment(s) will be made directly to the service provider.
   - Applicants are responsible for notifying their service provider of payment agreement. TAF will not be responsible for fees accrued due to late payments or termination of services due to lack of notification to the service provider.
3. TAF will not pay for services that are reimbursable by insurance companies.
4. TAF does not permit the use of the organization's name or logo without permission.
5. TAF will not distribute funds or payments directly to the applicant.
6. TAF reserves the right to deny or cancel previously approved assistance, if any information within the application or noted during the interview is found to be not truthful or unlawful.

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By signing below, I agree the information I have provided in this application is true and correct, and to the stated eligibility requirements and the policies and procedures.

My signature is my agreement to accept The Atrium Foundations assistance if approved, where I give permission to The Atrium Foundation to contact or pay service providers directly, as needed.

____
APPLICANT PRINTED NAME & DATE

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APPLICANT SIGNATURE