Integrative Access
FOUNDATION
Expanding Choices. Empowering Healing.

Financial Assistance Grant Application

CONFIDENTIAL APPLICATION FORM
This application is used to evaluate eligibility for financial assistance grants from Integrative Access Foundation (IAF). All information will be kept confidential and used solely for grant evaluation purposes.

☐ I am the patient applying for assistance
☐ I am a parent or legal guardian applying on behalf of a minor
☐ I am a caregiver applying on behalf of the patient
☐ Other (please specify): _____

SECTION 1: APPLICANT/PATIENT INFORMATION

Full Legal Name _____
Date of Birth _____
Home Address _____
City _____ State _____ Zip _____
Phone Number _____
Email Address _____
Preferred Method of Contact ☐ Phone/Text ☐ Email ☐ Either

SECTION 2: APPLICANT AND PATIENT REPRESENTATION

Name of Parent/Guardian/Caregiver _____ Phone Number: _____
Relationship to Patient: _____ Email _____
Home Address _____

Authorization (Required if not completed by patient):
I certify that I am authorized to complete this application on behalf of the patient named above.
Signature: _____
Printed Name: _____ Date: _____

SECTION 3: MEDICAL INFORMATION

Cancer Diagnosis: _____ **Date of Diagnosis:** _____

☐ Active Treatment ☐ Maintenance Therapy ☐ Remission ☐ Recurrence

☐ Other: _____

Treating Physician Name: _____ Phys. Contact Info: (opt.) _____

IAF may request verification of diagnosis if application is selected for funding.

SECTION 4: REQUESTED INTEGRATIVE THERAPY

Type of Therapy Requested: (check all that apply)

☐ Hyperbaric Oxygen Therapy (HBOT)
☐ PEMF Therapy
☐ Red Light Therapy
☐ Infrared Sauna Therapy
☐ Nutritional Therapy / Counseling
☐ Integrative Oncology Consultation
☐ Functional Medicine Consultation
☐ Other (please specify): _____

Cont.

Name of Provider or Clinic: _____

Provider Address: _____

Provider Phone or Website: _____

Estimated Cost of Therapy: $_____ **Amount Requested from IAF:** $_____

Has therapy already begun? ☐ Yes ☐ No If yes, start date: _____

SECTION 5: FINANCIAL INFORMATION

Employment Status:

☐ Full-time
☐ Part-time
☐ Self-employed
☐ Unemployed
☐ Disabled
☐ Retired

Annual Household Income (range):

☐ Under $25,000
☐ $25,000–$50,000
☐ $50,000–$75,000
☐ $75,000–$100,000
☐ $100,000–$150,000
☐ Over $150,000

Number of people supported by this income: _____

Does insurance cover the requested therapy? ☐ Yes ☐ No ☐ Partially

If partially, estimated out-of-pocket cost: $_____

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SECTION 6: PERSONAL STATEMENT

Please briefly share your story and explain how this therapy may support your healing, recovery, or quality of life. You may attach additional pages if needed.

SECTION 7: CONSENT AND CERTIFICATION

By signing below, I certify that the information provided is true and accurate to the best of my knowledge.

I understand that:

- Submission of this application does not guarantee funding
- Integrative Access Foundation provides financial assistance grants only and does not provide medical advice
- Funds will be paid directly to providers
- Additional documentation may be requested

Applicant Signature: _____

Printed Name: _____

Date: _____

SECTION 8: OPTIONAL SUPPORTING DOCUMENTS

Please attach if available:

☐ Physician note confirming diagnosis
☐ Cost estimate from provider
☐ Personal statement (optional additional page)

FOR INTERNAL USE ONLY (IAF)

Application Received Date: _____

Application Complete: ☐ Yes ☐ No

Committee Review Date: _____

Decision: ☐ Approved ☐ Denied ☐ Deferred

Grant Amount Approved: $_____

Approval Signatures:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Notes:

Integrative Access Foundation is committed to serving cancer patients with integrity, compassion, and fairness. All applicants will be evaluated using consistent and objective criteria.