



Empathy in Action Grant Application

Mission Statement: Enhance the quality of life of brain tumor patients and care providers With Intentional Kindness and Support – no journey is traveled alone!

Empathy in Action provides grants for tangible assistance (i.e., goods, services and/or funds) to brain tumor patients and caregivers in accordance with our charitable purposes. Awarding of grants shall be based on determination of financial need. **Patients whose annual household income exceeds 300% of the [Federal Poverty Guidelines](#) are ineligible for assistance under this program.** Grants up to \$1000 will be awarded. **No more than one grant will be issued to the same household.**

Empathy in Action only provides support for incidental expenses and does not include medical expenses or copays. Incidental expenses include transportation services, mobility services, meals, lodging, and other incurred expenses.

WINKS plans to award 3 – 4 grants annually. Grants decisions will be made quarterly. Individuals awarded grants shall be selected regardless of race, religion, sex, sexual orientation, age, marital status, disability, or gender identity.

Grant Eligibility

Note: If you have health insurance, you are still eligible to apply for this grant, if you meet all other eligibility requirements

Application Checklist

*****Incomplete applications will not be considered. *****

MUST include the following:

1. Signed application
2. Signed consent form
3. Copy of driver's license or state identification
4. Copies of all income sources
5. Copies of all current bills/creditor statements
6. Copies of the most current bank statements – 3 months
7. Confirmed diagnosis and treatment by Nurse Navigator/Social Worker

Please send completed application and consent form to WINKS, P.O. Box 5186, Suffolk, VA 23435 or email to support@winksfromgod.org.

WINKS is a tax-exempt under section 501(c)(3) of the Internal Revenue Code and a charitable organization under Virginia law and must adhere to applicable laws and regulations.



Empathy in Action Grant Application

☐ ***Please check here if you are applying for the Terrelle Bradshaw EIA Grant to be awarded in August 2021. Proof of military affiliation must be included.***

Date of Application: _____

SECTION A - PERSONAL INFORMATION

Applicant's Name: _____	Patient's Name: _____
Patient's Date of Birth: _____	Last 4 of Patient's SSN: _____
Address: _____ City, State, Zip: _____	
Phone Number: _____	Email Address: _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Spouse's Name: _____	Spouse's Phone Number: _____
Emergency Contact Person: _____	Emergency Contact Phone: _____

SECTION B - EMPLOYMENT

Employer's Name: _____	Position: _____
Employer's Address: _____	Employer's Phone Number: _____
Spouse's Employer's Name: _____	Position: _____
Spouse's Employer's Address: _____	Employer's Phone Number: _____

SECTION C - MEDICAL INFORMATION: **Must be completed by Nurse Navigator or Social Worker Only. The organization will contact to verify the provided information.**

Name of Physician: _____	Primary Treatment Facility: _____
Diagnosis: _____	Date of Diagnosis: _____
Recurrence: <input type="checkbox"/> Yes or <input type="checkbox"/> No	Under Treatment: <input type="checkbox"/> Yes or <input type="checkbox"/> No
Date of Last Treatment: _____	
Type of Treatment Received: _____	
Type and Frequency of Follow-up Treatment: _____	
<input type="checkbox"/> Nurse Navigator <input type="checkbox"/> Social Worker Name: _____	
Phone Number: _____	Fax Number: _____
Email: _____	
Signature of Nurse Navigator/Social Worker: _____	Date: _____

SECTION D - PURPOSE OF REQUEST

<p>Empathy in Action only provides support for incidental expenses and does not include medical expenses or copays. Grants may include funding for home services, mobility services, meals, lodging, and other incidental expenses. What incidental assistance do you need?</p> <p><input type="checkbox"/> Transportation <input type="checkbox"/> Lodging <input type="checkbox"/> Meals <input type="checkbox"/> Mobility <input type="checkbox"/> Home Services <input type="checkbox"/> Other _____</p> <p>Provide details of incidental assistance needed, e.g., transportation for medical appointments, ramp for home, delivery of meals, lawncare, traveling out of town for treatment, etc.:</p>

Empathy in Action Grant Application

SECTION E - HOUSEHOLD MEMBERS: Please list all the people in your household, including yourself.

Name	Age	Relationship	Income? Yes or No
1.			
2.			
3.			
4.			
5.			
6.			

SECTION F - MONTHLY HOUSEHOLD FINANCES: Give monthly income for yourself and ALL other household members. In general, **annual household income exceeding 300% of the Federal Poverty Guidelines are ineligible for assistance.** All requests must include sufficient documentation. Attach copies of proof of income, assets, and bills. **No more than one grant will be issued to the same household in the same year.**

Monthly Household Gross Income (before deductions)		Monthly Household Expenses	
Wages/Self-Employment	\$	Rent/Mortgage	\$
Social Security/SSI (Supplemental Security Income)	\$	Utilities and Telephone	\$
Pension or Retirement	\$	Groceries/Food	\$
Alimony/Child Support	\$	Child/Dependent Care	\$
Disability – Veteran Administration, Social Security Disability, Short/Long-Term	\$	Transportation – Car Payment/Gas/Insurance	\$
Worker's Compensation	\$	Out of pocket medical expenses	\$
Other – Public Assistance, Unemployment, etc.	\$	Other – Health Insurance, Child Support, etc.	\$
TOTAL MONTHLY GROSS INCOME	\$	TOTAL MONTHLY EXPENSE	\$

Other Resources/Investments – List					
Cash	\$	Stocks/Bonds	\$	Mutual Funds	\$
Bank accounts	\$	Money Market	\$	Other	\$
TOTAL RESOURCES/INVESTMENTS: \$					

SECTION G- STATISTICAL INFORMATION: *Information in this section is used for statistical purposes only. I understand that receiving assistance is not contingent on providing this information.* ☐ YES ☐ NO

Gender: Male Female	Race: American Indian or Alaska Native Asian
Black or African American	Native Hawaiian/Other Pacific Islander White
Ethnicity: Hispanic/Latino Not Hispanic/Latino	

SECTION H: APPLICANT'S SIGNATURE

I, _____ (Print Name), certify that all the information listed above is accurate and complete to the best of my knowledge. I also understand that deliberate misrepresentation of information may subject me to denial of assistance and/or services.	
Signature: _____	Date: _____

CONSENT FORM

I _____ (Name) residing at _____

(Address) hereinafter referred to as I or my, hereby consent to the following:

1. WINKS has my expressed permission to discuss this application with any others deemed necessary to verify my information and/or identify additional sources of assistance. I understand that all information will remain as private as possible between these entities.

Signature

Date

2. WINKS has my expressed permission for the use of my story and/or image (last name will never be used). I understand that my image and/or story may be used in connection with all charitable fundraising efforts, including being published on websites promoting a charity event and or in press releases, articles, news stories, and or other related media. The right to my image and/or story is granted worldwide and in perpetuity, but only for use as set forth herein and not in any other manner.

Signature

Date

3. If I am awarded a grant from WINKS I certify, promise, and affirm that I will utilize such grant for the specified intended purposes thereof, and for no other purpose. I understand that this promise is a material condition of being awarded a grant.

Signature

Date