WINKS WITH INTENTIONAL KINDNESS AND SUPPORT Serving the Brain Tumor Community

Empathy in Action Grant Application

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

The Empathy in Action grant program provides financial assistance to brain tumor patients and caregivers with demonstrated financial need in accordance with WINKS' charitable purposes. **Patients and caregivers whose annual household income is less than 300% of the Federal Poverty Guidelines** are **eligible for assistance under this program.** WINKS awards grants of up to \$1000 per household. No more than one grant will be issued to the same household within a six-month period.

WINKS recognizes the extraordinary financial burden a brain tumor diagnosis can place on a family. To alleviate this burden, the Empathy in Action grant program provides support for ordinary and necessary living expenses, including rent, mortgage payments, utilities, maintenance, food, clothing, insurance, medical expenses, transportation, mobility, and support expenses. Patients and caregivers may apply regardless of whether a patient has health insurance.

Grant awards will be made on an ongoing basis, and patients and caregivers are encouraged to apply at any time. WINKS will award grants without regard to race, religion, sex, sexual orientation, age, marital status, disability, gender identity, and without bias.

Application Checklist

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

Applications 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, consent form, and copies of all supporting documentation to WINKS, P.O. Box 5186, Suffolk, VA 23435, or email to support@winksbt.org.

WINKS is a qualified 501(c)(3) tax-exempt organization.



Empathy in Action Grant Application

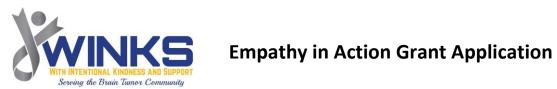
	Date of Application:
SECTION A – PATIENT'S PERSONAL I	INFORMATION
Name:	
	Last 4 Digits of SSN:
Address	City, State, Zip:
Phone Number:	Email Address:
Marital Status: ☐ Single ☐ Marrie	ed 🔲 Divorced 🔲 Separated 🔲 Widowed
☐ Partnered (civil	union or registered domestic partnership)
Spouse's Name:	Spouse's Phone Number:
	Emergency Contact Phone:
	AL INFORMATION (IF DIFFERENT FROM PATIENT)
Name:	Relationship to Patient:
Address:	City, State, Zip:
	Email Address:
SECTION C – EMPLOYMENT	
	Position:
	Employer's Phone Number:
	Position:
	Employer's Phone Number:
	ON: **Must be completed by Nurse Navigator or Social nurse navigator or social worker to verify information.**
•	
	Primary Treatment Facility:
	Date of Diagnosis: ler Treatment: ☐ Yes or ☐ No Date of Last Treatment:
_	er freatment: Tes or No Date of Last freatment:
	reatment:
	ker Name:
	Fax Number:Email:
	al Worker:Date:
SECTION E - PURPOSE OF REQUEST	
	e needed, such as assistance with rent, mortgage payments, utilities rance, medical expenses, transportation, mobility, or other suppor



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SECTION F - HOUSEHOLD MEMBERS: Please list all persons living in the patient's household,	, including the
patient.	

1. 2. 3. 4. 5. 6. SECTION G - MONTHLY HOUSEHOLD FINANCES: Give monthly income for the patient and all other house members. All requests must include sufficient documentation. Attach copies of proof of income, as and bills. Monthly Household Gross Income (before deductions) Monthly Household Expenses Wages/Self-Employment \$ Rent/Mortgage \$ Social Security/SSI (Supplemental Security \$ Utilities and Telephone \$ Income) Pension or Retirement \$ Groceries/Food \$ SAlimony/Child Support \$ Child/Dependent Care \$ Insurance \$ Security Disability. Veteran Administration, Social \$ Transportation - Car \$ Payment/Gas/ Insurance \$ Out of pocket medical expenses \$ Other - Public Assistance, Unemployment, \$ Other - Health Insurance, Child \$ Support, etc. TOTAL MONTHLY GROSS INCOME \$ 0.00 TOTAL MONTHLY EXPENSE \$ 0.00 TOTAL MONTHLY EX	Name		Age	Relations	hip Ir	ncome?	Yes or No	
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	•	complete to the b	est of my l		•			
misrepresentation of information may result in denial of assistance and/or services.		•	-	_				



CONSENT FORM

I	(Name) residing at				
(Addre	ss) hereinafter referred to as I or my, hereby conse	nt to the following:			
1.	, , ,	n to discuss this application with any others rmation and/or identify additional sources of assistance. I vavor to keep information as private as possible, but			
	Signature	Date			
2.	WINKS has my expressed permission for the use of will never be used). I understand that my image at charitable fundraising efforts, including being put and or in press releases, articles, news stories, and and/or story is granted worldwide and in perpetuing in any other manner. If I am not comfortable with that I may inform WINKS in writing, and WINKS we marketing and fundraising efforts.	nd/or story may be used in connection with all plished on websites promoting a charity event or other related media. The right to my image ity, but only for use as set forth herein and not the use of my story and/or image, I understand			
	Signature	 Date			
3.	f 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			