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.

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Date of Application: _____

SECTION A – PATIENT'S PERSONAL INFORMATION

Name:_____

Date of Birth:_____ Last 4 Digits of SSN:_____

Address_____ City, State, Zip:_____

Phone Number:_____ Email Address:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

☐ Partnered (civil union or registered domestic partnership)

Spouse's Name:_____ Spouse's Phone Number: _____

Emergency Contact Person:_____ Emergency Contact Phone: _____

SECTION B – APPLICANT'S PERSONAL INFORMATION (IF DIFFERENT FROM PATIENT)

Name:_____ Relationship to Patient:_____

Address:_____ City, State, Zip:_____

Phone Number:_____ Email Address: _____

SECTION C – EMPLOYMENT

Patient's Employer:_____ Position:_____

Employer's Address:_____ Employer's Phone Number: _____

Spouse's Employer:_____ Position: _____

Employer's Address:_____ Employer's Phone Number: _____

SECTION D - MEDICAL INFORMATION: **Must be completed by Nurse Navigator or Social Worker Only. WINKS will contact nurse navigator or social worker to verify information.**

Name of Physician:_____ Primary Treatment Facility: _____

Diagnosis:_____ Date of Diagnosis:_____

Recurrence: ☐ Yes or ☐ No Under Treatment: ☐ Yes or ☐ No Date of Last Treatment: _____

Type of Treatment Received:_____

Type and Frequency of Follow-up Treatment: _____

☐ Nurse Navigator ☐ Social Worker Name: _____

Phone Number:_____ Fax Number:_____ Email:_____

Signature of Nurse Navigator/Social Worker:_____ **Date**:_____

SECTION E - PURPOSE OF REQUEST

Please outline financial assistance needed, such as assistance with rent, mortgage payments, utilities, maintenance, food, clothing, insurance, medical expenses, transportation, mobility, or other support expenses.

_____

_____

_____

_____

_____

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

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

SECTION G - MONTHLY HOUSEHOLD FINANCES: Give monthly income for the patient and all other household members. All requests must include sufficient documentation. Attach copies of proof of income, assets, and bills.

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	$ 0.00	**TOTAL MONTHLY EXPENSE**	$ 0.00

Other Resources/Investments – List					
Cash	**$**	Stocks/Bonds	$	Mutual Funds	$
Bank accounts	**$**	Money Market	$	Other	$
TOTAL RESOURCES/INVESTMENTS:		$ 0.00			

SECTION G- PATIENT DEMOGRAPHIC INFORMATION: *Information is this section is used for statistical purposes only. Assistance is not contingent on providing this information.*

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

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 result in denial of assistance and/or services.

Signature:_____ Date:_____

WINKS
With Intentional Kindness and Support
Serving the Brain Tumor Community

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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 WINKS will endeavor to keep information as private as possible, but confidentiality is not guaranteed.

_____ _____

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. If I am not comfortable with the use of my story and/or image, I understand that I may inform WINKS in writing, and WINKS will refrain from using my story and/or image in marketing and fundraising efforts.

_____ _____

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