Grant Application

The Stem Well

Overview

The Stem Well provides emergency funding to assist pediatric cancer patients and their parent(s) or primary caregiver(s) who are experiencing financial hardship due to the patient's treatment or care.

Assistance Available

- Gas Card
- Grocery Card

Gas Card Eligibility

1. Demonstrated financial need/hardship.
2. Pediatric cancer patient must receive treatment from a hospital or cancer center located in Northeast Ohio.
3. If receiving outpatient care, patient must travel 15 miles or more (one way) a minimum of 2 times per month for treatment and/or Dr. appointments.
4. If receiving inpatient care, patient's parent(s) or primary caregiver(s) must travel 15 miles or more (one way) a minimum of 3 times per week to support patient.

Food Card Eligibility

1. Demonstrated financial need/hardship.
2. Pediatric cancer patient must receive treatment from a hospital or cancer center located in Northeast Ohio.

How to Submit Application

1. Parent/caregiver and/or patient if over 18 complete the application.
2. Application must be submitted by a **medical social worker** (who works at the hospital or cancer center patient is receiving treatment) on behalf of patient. This program is open to **any pediatric cancer patient receiving treatment from a hospital or cancer center located in Northeast Ohio.**

Application Review, Award Notification, and Award Delivery

Applications will be reviewed weekly. We will review each request carefully and award aid based on sufficient documentation of need and availability of funds. If awarded a grant, an award notification will be emailed to the applicant and social worker listed on the application. If awarded, the patient's grant will either be hand-delivered to the social worker or mailed to the social worker at their hospital/center of record through USPS (registered mail), UPS, or FedEx. Patients/families then coordinate award pick up with the social worker and upon pick up must sign a form confirming the same (which will be returned to **The Stem Well** by the Social Worker).

How often can an application be submitted?
Twice per year and must not be submitted in the same month.

What is the maximum Grant Award available?
Per application grant not to exceed $200. Per year grant not to exceed $400. Note, approved grants can range from $25.00 per application to $200 (based on demonstrated need and available funding).

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Applying for ☐ Gas Card ☐ Food Card ☐ Both

Patient Information

First Name _____ Last Name _____ Middle Initial _____

Age of Patient _____

Address _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

Current Care Status ☐ Inpatient or ☐ Outpatient (Select Appropriate Box)

Treatment location _____
(Hospital or Cancer Facility Name)

_____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

_____ _____
(Physician name) Year of cancer diagnosis

- **If outpatient**, how many times does patient travel per month for treatment or Dr.'s appointments? _____

Parent, Caregiver or Applicant Information

First Name _____ Last Name _____ Middle Initial _____

Date of Birth _____ Relationship to patient _____

Address _____ _____ _____ _____
(Street Address) (City) (State) (Zip Code)

Number of people in family/household (including patient) _____

Annual Household Income _____ email address _____

Phone Number _____

- **If patient is an inpatient**, how many times do you travel per week to visit/support patient? _____

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Briefly describe financial hardship and how grant would help.

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Applicant Acknowledgement(s) and Certification

I understand that if awarded, this one-time grant is not compensation. I further understand and agree that if awarded, the grant must not be transferred or sold to another individual or entity. I further understand and agree that if awarded, the grant must be used for its intended purpose(s). I further certify that the information provided in the application is accurate. Finally, I certify that patient is a pediatric cancer patient.

_____

Applicant - First Name, Last Name (Print)

_____ _____

Applicant - First Name, Last Name (Signature) **Date**

To Be Completed By Hospital

Social Worker Information

First Name _____ **Last Name** _____
(print) (print)

License Number _____

Employed at _____

email address _____

Mailing Address _____ _____
(Hospital Street Address) Attention, Box # or Building #

_____ _____ _____
(city) (state) (zip)

_____ _____
Social Worker – First Name, Last Name (Signature) **Date**