Shadows Foundation

PO Box 3026
Flagstaff, Arizona 86003

www.ShadowsFoundation.org
Contact:
Vicki@shadowsfoundation.com
Fax: 928-255-4315

Dear Social Worker or Health Care Professional,

Shadows Foundation requires that an applicant work with a social worker or health care professional to help them complete our application for financial assistance. The health care professional will also serve as our main contact if questions arise regarding the patient's application.

Here is an overview of Shadows Foundation's procedures. Please contact us if you have any questions or concerns.

Shadows Foundation Procedures:

1. The Medical Information Form needs to be completed by a social worker or health care professional. A Physician or Nurse needs to **(a) verify the patient's diagnosis** and is **(b) currently undergoing treatment**. Medical records do not need to be sent. If the patient is in hospice, a social worker is allowed to sign this form.

2. The Patient Information Form and Release Form need to be completed by the patient, including a signature.

3. Please mail or fax all completed paperwork to the address/fax number listed on the cover page. Upon receipt of the paperwork, Shadows Foundation will contact the patient, social worker or health care professional, and Physician via mail or email to inform them of the qualifying grant details.

4. **All three pages of the application must be completed** in order to be processed. **Incomplete applications will be returned** for completion and will not be reviewed until a completed application is submitted.

5. Upon receipt of the acceptance letter, depending on patients needs the patient may be required to meet with a financial advisor provided by Shadows before final approval. Please allow for 5-7 business days for response to application request.

6. Home visits and meeting may be required for extended funding.

7. All applicants requesting help with monthly utility bills will be required to supply a copy of their recent bills. Utility bill **must be in patients name** in order to provide assistance. A maximum of 3 months will be provided for applicant.

FUNDING GUIDELINES

Service Area

- **Patient must live within Coconino/Yavapai** County and be a residence for no less than one year prior to request for assistance.
- One-time gas/food Card request may be granted upon approval to out of area residence receiving treatment within Coconino/Yavapai County.

Funding Time Line

- If approved applicants are eligible for three months. Those needing extended assistance beyond the three months may reapply for additional assistance.

Grant Requirements

- Patient must have a diagnosis and be in active treatment. Active treatment does not include surgery.
- Applicant must be 18 years or older or submitted by a parent or guardian.
- The Medical Information Form must be completed by a social worker or health care professional. A Physician or Nurse needs to sign the Medical Information Form to confirm the diagnosis.
- Patient must meet financial guidelines set by Shadows Foundation. The Release Form must be signed by the patient or legal guardian.

Eligible Requests

- Medications not covered by insurance
- Accommodation Expenses
- Utility assistance
- Household repairs
- Personal home care assistance
- Assistance with foods for individuals with special diets
- Cost for required programs needed for rehabilitation after illness
- Transportation
- Food/Gas cards

Ineligible Requests

- The organization does not approve requests for payment on bills such as rent, mortgage payments or insurance deductibles.

Administration

- Funding will be disbursed directly to the vendor or your medical facility upon meeting all requirements by Shadows

Application submit to: Shadows Foundation P.O. Box 3026 Flagstaff AZ 86003 (F) 928-255-4315

MEDICAL INFORMATION FORM
TO BE FILLED OUT BY HEALTH CARE PROFESSIONAL

Date: _____

Patient Information:

First Name:_____ Last Name:_____

Birth Date:_____/_____/_____Gender: M___ F___Social Security #: _____-_____-_____

Diagnosis: _____Stage: _____Date of Diagnosis: _____

Current Treatment: (PLEASE SPECIFY):
_____
_____
_____

TO BE SIGNED BY TREATING PHYSICIAN OR NURSE ONLY

I attest the patient diagnosis and is currently being treated as stated above

X_____

Clinic Information:

Clinic:_____Physician: _____

Address: _____

City: _____State:_____ Zip:_____

Phone: (_____) _____-_____ Alt. Phone: (_____) _____-_____

Email: _____

Social Worker/ Health Care Professional Information:

Name:_____Phone: (____) _____-_____

Clinic/ Organization:_____

Address: _____

City: _____State:_____ Zip:_____

Phone: (_____) _____-_____ Alt. Phone: (_____) _____-_____

Email: _____

*Information regarding the qualifying amount for this patient will be sent to you via email

Please inform us why the patient is in need of Financial Assistance: (REQUIRED):

Patient Information Form

Patient Information:

First Name:_____ Last Name:_____

Address: _____

City: _____State:_____ Zip:_____

Phone: (_____) _____-_____ Alt. Phone: (_____) _____-_____

Email: _____

Inform me regarding my application via (circle one) **Email** **Mail**

Responsible Party (If different than above):

First Name:_____ Last Name:_____

Address: _____

City: _____State:_____ Zip:_____

Phone: (_____) _____-_____ Alt. Phone: (_____) _____-_____

Email: _____

Do you drink alcohol?	Yes / No	If so, how much?_____
Do you use tobacco?	Yes / No	If so, how much?_____
Do you exercise?	Yes / No	If so, how much?_____

Please list the people in your household:

	Name	Date of Birth	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Financial Information

Total Monthly Household Income (after taxes): $_____

Estimated Monthly Expenses			Estimated Household Assets	
Rent/Mortgage:			Checking:	
Utilities / Phone:			Savings:	
Child Care:			CD / Stocks / Bonds:	
Groceries:			Money Market:	
Medical Expenses:			Other:	
Other:				

Please provide additional comments regarding your situation that might be helpful when reviewing your application.

RELEASE FORM

I declare that the information on this application is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made by Shadows Foundation. I hereby give my permission that this application and all information provided can be sent to Shadows Foundation and discussed with my health care professional. All information reviewed is confidential.

Patient Signature: _____ Date:_____

Print Name:_____

Please take some time to answer the questions below.

I would like to be on Shadows Foundation mailing list: _____ Yes _____ No

How did you hear about Shadows Foundation?

_____ Social Worker:_____

_____ Physician: _____

_____ Nurse Name: _____

_____ Friend Name:_____

_____ Internet:_____

_____ Brochure:_____

_____ Other: _____

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*SEE INCOME GUIDELINES BELOW

Number In Household	Annual Income Between 100%-250%	Monthly Income Between 100%-250%
1	$10,830-$27,075	$903-$2,256
2	$14,570-$36,425	$1,214-$3,035
3	$18,310-$45,775	$1,526-$3,815
4	$22,050-$55,125	$1,838-$4,594
5	$25,790-$64,475	$2,149-$5,373
6	$29,530-$73,825	$2,461-$6,152