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
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):

__________________________________________

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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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Financial Information

Total Monthly Household Income (after taxes): $_______________

<table>
<thead>
<tr>
<th>Estimated Monthly Expenses</th>
<th>Estimated Household Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rent/Mortgage:</td>
<td>Checking:</td>
</tr>
<tr>
<td>Utilities / Phone:</td>
<td>Savings:</td>
</tr>
<tr>
<td>Child Care:</td>
<td>CD / Stocks / Bonds:</td>
</tr>
<tr>
<td>Groceries:</td>
<td>Money Market:</td>
</tr>
<tr>
<td>Medical Expenses:</td>
<td>Other:</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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

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