Please Read Before Applying

We approve applicants based on the following:

1. **First-come, first-served basis**
2. Allocated funds we have available to fund each year
3. Cancer facility that has accepted the applicant as a patient
4. Letter showing you have been accepted as a patient for treatment
5. Cancer treatment program and cost

Required with the application: Income and expenses, <u>including spouse/ partner</u>

- Proof of the last three months of rent payments or mortgage payments
- Proof of utility expense
- Last three months of personal bank statements, including savings
- Tax returns for the last two years
- Rental, property, or investment income
- Income from IRAs, 401K plans, pensions, and other retirement or savings accounts
- Retirement, government, and pension income

Proof of income

- Commissions, bonuses
- Unemployment income
- Disability Income
- Employment offer letter
- Pay stubs, etc.
- Proof of other income (e.g., alimony, child support)
- Crowdfunding income, charitable gift donations in your name
- Proof of liquid assets (cash, money market instruments, marketable securities)
- Digital Assets (End of Year Statement)

Self-employed

- Proof of income
- YTD business Profit and Loss
- Last three months of business bank statements
- Business tax returns for the previous two years

Options For Life Foundation
PO Box 8476 Calabasas, CA 91372-8476
Email: info@oflfoundation.org

CONFIDENTIAL APPLICATION

General Information: *Please answer all questions*

Applicant's Name:	Social Security No.:	Birthdate:
Address:	Home Phone No.:	Work Phone No.:
	Cell Phone No.:	Fax No.:
Employment Status: ☐ Retired ☐ Disabled ☐ Employed ☐ Unemployed		
Spouse's/Partner's Name:	Social Security No.:	Birthdate:
Spouse's/Partner's Address (if different):	Spouse's/Partner's Telephone No's (if different) Home Phone No.:	Work Phone No.:
	Cell Phone No.:	Fax No.:
Employment Status: ☐Retired ☐Disabled ☐Employed ☐Unemployed		

Name two individuals who can be contacted if you cannot be reached: (Such as adult children, friends, etc.)

Name:______________________________ Relationship:______________

Address/Phone No.:______________________________

Name:______________________________ Relationship:______________

Address/Phone No.:______________________________

List current/former employer(s), position(s) held, and year(s) employed.

Employer Name	Position(s) Held	Year(s) employed

Health Information:

Applicant's Doctor:______________________________ Phone No.:______________

Spouse's Doctor:______________________________ Phone No.:______________

Name of Applicant's Primary Health Insurance:______________ Policy Number:______________

Name of Applicant's Secondary Health Insurance: ______________ Policy Number:______________

Name of Spouse's Primary Health Insurance:______________ Policy Number:______________

Name of Spouse's Secondary Health Insurance: ______________ Policy Number:______________

Please indicate any health conditions, or illnesses:______________________________

____

____

____

If you do not have income or expenses, please check this box ☐, sign below and return with application

Income (from employment, unemployment, disability, charity grants, pension, social security, rental income, dividends, interest income, alimony, etc.)

Applicant:

1. Issued by: ____________________
   Amount: ____________________
2. Issued by: ____________________
   Amount: ____________________
3. Issued by: ____________________
   Amount: ____________________

Spouse:

Issued by: ____________________
Amount: ____________________

Issued by: ____________________
Amount: ____________________

Issued by: ____________________
Amount: ____________________

Expenses: (Estimate basic monthly costs)

Type of Expense	Monthly Amount	Type of Expense	Monthly Amount
Rent:		Car Loan:	
Renter's Insurance:		Car Lease Payment:	
Mortgage:		Car Insurance:	
Home Owner's Insurance:		Gasoline Costs:	
Property Taxes:		Other transportation costs:	
Food/Household supplies:		Installment debts:	
Electric/Gas/Water/Garbage:		Installment debts:	
Telephone:		Installment debts:	
Life Insurance:		Other expenses:	
Medical Insurance:		Other expenses:	
Medications not covered by insurance:			
Medical co-pays or deductibles:			

List the names and ages of those who live in the home:
____

Real Estate (Primary Residence, Vacation Home, Rental Property, Vacant Land, Etc.)

Address: ____________________ City: __________ State: ______ Zip __________

Monthly Mortgage: ____________________ Balance Owed: __________ Current Value: __________

Bank Accounts, Credit Union Accounts, Retirement Accounts:

Institution: ____________________ Institution: ____________________
Current Balance: ____________________ Type of Account: ____________________

Institution: ____________________ Institution: ____________________
Current Balance: ____________________ Type of Account: ____________________

Additional assets, list here:

Other Personal Property (Automobiles, Recreational Vehicles, Boats, Motorcycles, Etc.)	
Description:______________________________	Value:______________________________
Registered Owner:__________________________	Legal Owner:__________________________
Balance Owing:____________________________	Market Value:_________________________
Are Payments Delinquent?: ☐ Yes ☐ No	If so, Amount:________________________
Description:______________________________	Value:______________________________
Registered Owner:__________________________	Legal Owner:__________________________
Balance Owing:____________________________	Market Value:_________________________
Are Payments Delinquent?: ☐ Yes ☐ No	If so, Amount:________________________

RELEASE OF INFORMATION, FINANCIAL DISCLOSURE AND UNDERSTANDING:

Please initial after each statement and sign at the bottom of the application:

1. I hereby certify that I have answered the foregoing questions to the best of my ability, the facts therein stated are true and I understand that any misrepresentation of this information may disqualify me for any assistance from the Options For Life Foundation. I further agree to notify the Options For Life Foundation of any changes in my financial situation if such occurs during the time I am receiving assistance. **(Applicant's initials)________(Spouse's/Partner's initials)________**

2. I authorize any insurance company, organization, employer, hospital, physician or pharmacist to release any information requested with regard to medical treatment, dates of medical service, health condition, and medical expenses to the Options For Life Foundation and its representatives.
(Applicant's initials)________(Spouse's/Partner's initials)________

3. I hereby authorize the Options For Life Foundation and its representatives to communicate with responsible relatives to secure information regarding earnings from employers, to contact financial institutions for financial data and to contact any other agency or persons regarding my financial status. **(Applicant's initials)________(Spouse's/Partner's initials)________**

4. The undersigned, recognizing that his or her individual credit history may be a necessary factor in the evaluation of this application, hereby consents to and authorizes the use of a consumer credit report on the undersigned, by Options For Life Foundation .
(Applicant's initials)________(Spouse's/Partner's initials)________

5. I agree to provide all disclosures of my financial assets. I agree that by submitting this application I have not given away or transferred any assets within the last 12 months in order to qualify for assistance. I understand that if the Options For Life Foundation discovers such a give-away or transfer, my assistance will be terminated immediately.
(Applicant's initials)________(Spouse's/Partner's initials)________

6. I understand that the assistance I may receive is charitable in nature and intended to provide support during a short recovery or adjustment period. I understand that if I am granted assistance while owning liquid assets worth up to three (3) times my usual monthly income, I will use these assets wisely to meet necessary monthly obligations. The Options For Life Foundation views liquid assets as those assets which can be quickly and cheaply converted into cash such as bank deposits, money market fund shares, U.S. treasury bills, and recreational vehicles, etc. Other assets such as one's primary home is viewed as an illiquid asset, which generally can only be sold after a long search for a buyer.
(Applicant's initials)________(Spouse's/Partner's initials)________

*Please enclose your most recent tax return in addition to submitting this completed application.

The items initialed above indicate that I have read them and am in full agreement.

____
Date Applicant's Signature

____
Date Spouse's Signature

RELEASE TO OBTAIN AND DISCLOSE INFORMATION

I/We, ________________________, authorize the Options For Life Foundation™ Social Services staff to obtain and disclose pertinent information from my/our records to/from the indicated entities:

☐ Insurance company
☐ Organizations
☐ Employer
☐ Hospital/Doctor's Office
☐ Local/Union
☐ Physician
☐ Pharmacist
☐ Utility companies
☐ Other:

This authorization is valid only for the period of one year from the date listed below at signature.

I/We understand that my/our records are protected under the Federal Confidentiality Regulations as well as the provisions of HIPPA of 1996 and cannot be disclosed without my/our written consent unless otherwise provided for the regulations. I/We understand that I/we may revoke this consent at any time, provided action has not been taken in reliance upon this authorization. Without written notice to withdraw this consent, it expires at the earlier of the listed expiration date or upon release of the information. The nature of this consent form has been explained to me/us and I/we understand its contents. I/We are aware that when my/our medical records reflect information concerning psychological or psychiatric impairments, drug abuse, and/or alcoholism, and/or information regarding human immunodeficiency virus (HIV) and other infectious diseases, that this information will be released as part of my/our medical records.

____

(Signature of Applicant) (Date)

____

(Signature of Applicant's Spouse) (Date)

Please fill application out completely, or it will be rejected.
You may send application via mail, fax or email:

www.oflfoundation.org

Mail: OPTIONS FOR LIFE FOUNDATION
PO Box 8476 Calabasas, CA 91372-8476
Fax: 818-710-6598
Email: info@oflfoundation.org