STAFF ONLY
Date/Time Received:

Cancer Support Community of Greater Ann Arbor's

Lodging Assistance Program

APPLICATION CHECKLIST:

In order to make sure that your application is eligible for consideration, please check that **all** of the following documents are included:

- ☐ Completed application:
  - ☐ Application checklist
  - ☐ Contact information
  - ☐ Medical information
  - ☐ Statement of income
- ☐ A signed and dated letter (on letterhead) confirming your diagnosis and need for local lodging for treatment including the type of treatment and treatment dates from a medical professional on your treatment team (*please select one of the following*):
  - ☐ Physician, nurse practitioner, or physician assistant
  - ☐ Nurse navigator
  - ☐ Patient navigator
  - ☐ Social worker
- ☐ Proof of residence (*e.g. utility bill, copy of ID, drivers license, or like documentation*)

Please submit your application via email to lodging@cancersupportannarbor.org, fax to 734-975-2525, or mail to:

Cancer Support Community of Greater Ann Arbor
Attn: Financial Assistance
2010 Hogback Rd. Suite 3
Ann Arbor, MI 48105

If you fail to honor your reservation without providing prior notice or explanation, you will become ineligible for any future lodging support services from the CSC.

CONTACT INFORMATION OF INDIVIDUAL COMPLETING FORM:

Name:_____

Relationship to applicant: _____

Preferred phone: _____

Secondary phone: _____

Email address: _____

CONTACT INFORMATION OF LODGING ASSISTANCE APPLICANT:

Name: _____

Address: _____

_____

Preferred phone: _____

Secondary phone: _____

Email address: _____

MEDICAL INFORMATION

Name of person with cancer: _____

Person diagnosed with cancer's date of birth: _____

Type of cancer: _____

Stage:

- ☐ 0
- ☐ I
- ☐ II
- ☐ III
- ☐ IV

Cancer treatment center: _____

Treating physician's name: _____

Treating physician's phone number: _____

HOTEL STAY INFORMATION

Expected arrival date: _____

Expected departure date: _____

Number of beds needed: _____

Names of any other individuals staying in the room: _____

_____

STATEMENT OF INCOME:

Total number of people in the household: _____

Number of working adults in household: _____

Number of children/dependents in household: _____

Monthly household income **before expenses**: _____

DEMOGRAPHIC INFORMATION:

The following questions are optional and will in no way affect your eligibility for Lodging Assistance but are required to be completed. Please complete the information below with the person with cancer's information.

Race (please check all that apply):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: _____
- ☐ Don't wish to answer

Ethnicity:

- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Don't wish to answer

Gender Identity:

- ☐ Man
- ☐ Woman
- ☐ Transgender man
- ☐ Transgender woman
- ☐ Nonbinary
- ☐ Other: _____
- ☐ Don't wish to answer

Insurance Type:

- ☐ Medicaid
- ☐ Medicare + Private
- ☐ Medicare
- ☐ Private
- ☐ Uninsured
- ☐ Don't wish to answer

CERTIFICATION AND CONSENT:

I hereby certify, under penalty of perjury, that the information set forth on this application is true and accurate and that the expenses for which I have requested financial assistance/lodging assistance impose a financial hardship for me. I understand that only the expenses approved through this application are covered. Further, myself or my loved one has been diagnosed with cancer, I/they are undergoing treatment for, or are in recovery from recent treatment for cancer, and do not have adequate resources or income to pay for the expenses. I understand that if any of the information set forth above is false, that my application will be null and void. Additionally, I understand that any tax implications are my responsibility and the Cancer Support Community does not provide any information directly to me for tax purposes.

By signing below, I hereby grant and give permission for representatives of the Cancer Support Community of Greater Ann Arbor to contact my physician(s) and/or medical team member(s) as needed.

Signature _____ Date _____