Financial Assistance Application

Moms on the Run provides financial assistance for everyday living expenses including, but not limited to, rent/mortgage, car payments, insurance, food, etc. Moms on the Run's goal is to help alleviate your financial stress while on your journey to wellness.

CRITERIA FOR ACCEPTANCE:
1. **Northern Nevada Resident**. Residency is determined by where a person primarily resides. Persons living in the Northern Nevada area are eligible for assistance.
2. **Active breast or gynecological cancer at time of application**. Medical records will be reviewed to verify the diagnosis of breast or gynecological cancer.
3. **Financial need**. Each person's financial situation is reviewed on an individual basis.
4. You will be **required** to provide copies of verification for out-of-pocket expenses, bills, and treatment.

**Due to limited funds, we are not able to help on a permanent basis; only for specified period.*

**Applications are only accepted online or by mail to Moms on the Run (5995 S. Virginia St., Reno, NV 89502). Please, no in-person applications.*

Date

Applicant Information

Name

First

Last

Address

Address Line 1

Address Line 2

City

State

Zip Code

Phone

Alternate Phone

Email

By supplying your email, you are opting in to receiving emails from MOTR. We will not share your email address.

Date of Birth

Age in years

Social Security Number

Include dashes

Employment

Currently Employed?

[ ] Yes [ ] No

If yes, part-time or fulltime?

Last Date Able to Work?

Occupation:

Employer:

Family

Marital Status

If Married, Spouse' Name?

Spouse's Occupation

Spouse's Employer

Children (list names and ages)

Medical

Date Diagnosed:

Type of Cancer

Hospital:

Oncologist/Surgeon:

Nurse Navigator/Social Worker:

Do you have insurance?

[ ] Yes [ ] No

If yes, Insurance Provider:

Do you have Medicaid?

[ ] Yes [ ] No

Medicaid Start Date:

Details about your diagnosis:

Please write detailed information about your breast/gynecological diagnosis (including dates)

Treatments:

Detail your treatments, including their start and end dates

Treatment Type 1

Treatment: | **Start Date:** | **End Date:**

Detailed description

Please provide additional details about this particular treatment

Treatment Type 2

Treatment: | **Start Date:** | **End Date:**

Detailed description

Please provide additional details about this particular treatment

Treatment Type 3

Treatment: | **Start Date:** | **End Date:**

Detailed description

Please provide additional details about this particular treatment

Treatment Type 4

Treatment: | **Start Date:** | **End Date:**

Detailed description

Please provide additional details about this particular treatment

Treatment Type 5

Treatment: | **Start Date:** | **End Date:**

Detailed description

Please provide additional details about this particular treatment

If you are undergoing additional treatments (other than those listed above), please detail them below:

Financial Assistance Resources

List other resources applied to for financial assistance
(including grants, welfare, public assistance, food stamps, etc.)

Resource 1

Name

Name/type of resource

Amount Received

Start Date:

End Date:

Resource 2

Name

Name/type of resource

Amount Received

Start Date:

End Date:

Resource 3

Name

Name/type of resource

Amount Received

Start Date:

End Date:

Resource 4

Name

Name/type of resource

Amount Received

Start Date:

End Date:

Resource 5

Name

Name/type of resource

Amount Received

Start Date:

End Date:

If you are receiving any additional resources (other than those listed above), please detail them below:

Financial Resources Statement

Please list all sources of family income.

Checking Account:

Savings Account:

Retirement/401K Account:

Employment Earnings:

Unemployment Benefits:

Veteran's Benefits:

Social Security Payments:

Retirement or Pension:

Child Support/Alimony:

Interest/Dividends:

Other:

Checking Account:

Savings Account:

Retirement/401K Account:

Monthly Income

Monthly Income Prior to Diagnosis

Your Current Monthly Income

Spouse/Partner/Family Net Income

Monthly

Total Monthly Household Net Income

If you have any additional financial resources or income (other than those listed above), please detail them below:

Monthly Expenses

Do you pay rent or mortgage?

Monthly Cost of Rent/Mortgage

Food Costs:

Monthly

Car Payment:

Car Insurance:

Gasoline Costs:

Monthly

Utilities

List all utilities and their monthly bill amount

Utility 1

Type/Company

Current Bill Amount Due:

Utility 2

Type/Company

Current Bill Amount Due:

Utility 3

Type/Company

Current Bill Amount Due:

Utility 4

Type/Company

Current Bill Amount Due:

Utility 5

Type/Company

Current Bill Amount Due:

If you have any additional utilities or monthly expenses (other than those listed above), please detail them below:

Please specify the living expenses for which you are seeking assistance:

Please note: Moms on the Run may assist with everyday living expenses to help off-set your medical bills.

I hereby declare the previous pages to be a true and actual statement of my finances.

Name

First

Last

Date

Signature

Waiver and Release of Liability

I have requested financial aid from Moms on the Run, a non-profit charitable organization which assists women in northern Nevada during treatment of breast and gynecologic cancers. I understand that the granting of financial assistance by Moms on the Run is entirely discretionary at all times and that Moms on the Run may deny or terminate such aid for any reason at any time. I also acknowledge that I have the right to ask Moms on the Run any questions that I have or many have concerning available benefits, eligibility or this waiver.

I hereby agree to take all the actions that are or may be required of me pursuant to the application process, including, but not limited to providing all the necessary information to determine eligibility for benefits, which may be accomplished by executing the appropriate authorization and consent for the release of information to Moms on the Run.

On the basis of the forgoing, I, on behalf of myself and my heirs, successors and assigns, hereby waive and release Moms on the Run, including its officers, directors, employees and volunteers, from any and all claims, damages and/or costs of whatever kind, whether legal or equitable and whether based on theories of contract, tort, or otherwise, that I have now or in the future that may arise out of or relate in any way to my application for assistance from Moms on the Run and/or any grant, denial, increase or termination of assistance made as a result of my application or the process of review.

I have carefully read the forgoing release in its entirety and know and understand the contents thereof and sign the same as my own free act.

Date:

Name

First

Last

Social Security Number

include dashes

Signature

Authorization and Consent to Release Information to Moms on the Run

Doctors & Hospitals from whom you receive treatment

List of doctors and hospitals currently providing treatment

You are hereby authorized and directed to disclose, deliver or furnish to Moms on the Run, a non-profit charitable organization, 5995 S. Virginia St., Reno, Nevada 89502, or any representative of Moms on the Run, pursuant to HIPAA Privacy Rule (Section 164.508), copies of any and all medical and/or hospital records relating to the past, present or future physical condition of:

Patient's Name

Patient's Name

This release is also intended to authorize the disclosure of financial, employment and/or other personal information necessary to determine eligibility for benefits for which I have applied to Moms on the Run.

The release of information and/or disclosure authorized by way of this release may be made via telephone or written correspondence. This release is made for the sole purpose of establishing eligibility for benefits for which I have applied to Moms on the Run and is not a waiver of my privilege as to the content of those records for any other purpose. By signing this authorization, I understand that I may revoke this authorization at any time in writing. My written revocation will become effective upon receipt, but will not apply to any medical, financial, employment and/or other information and records released prior to that date or to the extent that your office/facility has taken action in reliance upon this authorization.

This authorization will expire one (1) year from the date of signature.

It is agreed that a photocopy of this authorization shall have the same force and effect as the original.

Date:

Name

First

Last

Signature