Revivals Health & Wellness Council

Express Joy

(The Leesha Runnels Resource Center)

ASSISTANCE APPLICATION

ELIGIBILITY CRITERIA:

1. No identifying information herein will be transferred to any other entity without the written consent of the applicant. All non-identifying information may be used for statistical purposes in order for Revivals to seek grants and donations.
2. *Northern Nevada Resident:* Residency is determined by the applicant's primary address.
3. *Resident Outside of Northern Nevada:* Service may be rendered to applicants living outside of Northern Nevada if there are no Northern Nevada residents on the waiting list for the same type of resource.
4. *Assistance Needed:* The need is determined on an individual basis.
5. By completing the application, the applicant understands and agrees to the following:
   a. The granting of assistance is entirely discretionary at all times. Revivals Health & Wellness Council may deny or terminate services to an applicant for any reason at any time.
   b. Only applications completed in full will be considered. Further verification of health screening, treatment, and/or recovery may be requested and will require the applicant to complete the ***Authorization and Consent to Release Information to Revivals Health & Wellness Council*** form, which will be provided. If this is the case, no approval will be granted for resources until verification is complete.
   c. Submitting of an application does not guarantee approval for resources.
   d. Applicants are notified upon receipt of the application. Applications are processed as quickly as possible.
   e. If the applicant is reapplying for assistance, an update of the initial application may be requested.
   f. Resources may be limited, which may result in a denial of services. In this case, the applicant may be placed on a waiting list and contacted once resources are available.

APPLICANT INFORMATION - Date: _____

Name: _____ ☐ Female ☐ Male

Address *(w/city, state, & zip)*: _____

Primary Telephone *(w/area code)*: _____ Age: _____ Date of Birth *(mm/dd/yyyy)*: _____

Social Security #: **May be required at some point** Spouse Full Name: _____

Children *(son or daughter)* & Age: _____

Employer: _____ Employer *(Spouse)*: _____

Date Diagnosed with Breast Cancer *(mm/yyyy)*: _____

Hospital(s) of Services: _____

Oncologist Name: _____ Address: _____

Surgeon Name: _____ Address: _____

Other Specialist: _____ Address: _____

Other Specialist: _____ Address: _____

Other Specialist: _____ Address: _____

Other Specialist: _____ Address: _____

[Description of Health]:

Details about your breast cancer diagnosis: _____

Revivals Health & Wellness Council

Name: _____

Date: _____

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Details about recommended treatment (including type and length): _____

Agencies applied to and received assistance from: _____

[Description of Finances]:

Do you have health insurance? ☐ Yes ☐ No Insurance Provider: _____

Monthly Expenses: Rent/Mortgage: _____ Food: _____ Utilities: _____ Child Care: _____

Car Payment: _____ Insurance: _____ Health Ins.: _____ Remaining: _____

Financial Resources:

Employment Earnings: $ _____ Unemployment Benefits: $ _____

Social Security *(SSI or SSD)*: $ _____ Veteran's Benefits: $ _____ Child Support/Alimony: $ _____

Welfare/Public Assistance/Food Stamps: $ _____ Retirement/Pension: $ _____

Other: $ _____ Savings Acct.: $ _____ Checking Acct: $ _____

Total Monthly Income: $ _____

[Description of Current Need(s)]:

HEALTH SCREENING *(What tests do you need and what is the cost?)*	**TREATMENT** *(What procedures do you need and what is the cost?)*	**RECOVERY** *(What items are you in need of?)*
		☐ Wig ☐ Cap ☐ Pillow ☐ Bra
		☐ Prosthesis/Breast Form ☐ Soft Tee
		☐ Transportation
		☐ Other _____
☐ Transportation	☐ Transportation	☐ Other

(What household expenses are in jeopardy while you are in recovery?)

WAIVER AND RELEASE OF LIABILITY: I hereby declare that I understand the eligibility criteria as indicated above. Further, that the above information I have provided is true concerning my health. I acknowledge that I have the right to ask Revivals Health & Wellness Council any questions or express concerns I have about their available resources, eligibility requirements, or this waiver. On the basis of the foregoing, I, and on behalf of myself and my heirs, successors, and assigns, hereby waive and release Revivals Health & Wellness Council, including its officers, directors, employees, and volunteers, for 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 Revivals Health & Wellness Council and/or any grant, denial, increase or termination of assistance made as a result of my application or the review process. I agree to maintain a copy of this application and letters of approval for my records, as I will not be able to retain copies from Revivals Health & Wellness Council. **I have carefully read the foregoing release in its entirety and know and understand the contents thereof and sign the same of my own free will and act.**

Printed Name _____ Signature _____ Date *(mm/dd/yyyy)* _____