February 8, 2016

POLICY AND GUIDELINES OF H.U.G.S. Charities Inc.
H.U.G.S. Allocation Committee Child with Cancer Application

The mission of the H.U.G.S. Charities Allocations Committee shall be to provide relief assistance for cancer patients and/or their family members that are affected by this illness. The H.U.G.S. Allocations Committee is not meant to be a permanent solution to a family's financial needs, but provide some relief. All applications and assistance/grants will be provided with the counsel of The Cancer Alliance of Marion County (CAMC) which is formed by H.U.G.S.

A. Criteria for assistance

1. The dependent child (a person under 18 years of age) must be currently diagnosed with cancer and actively receiving treatment from a Florida Oncology Practice.
2. There is a financial crisis where assistance from the H.U.G.S. Allocations Committee can provide relief to that crisis.
3. The person applying must be truthful on all forms and with questions from the H.U.G.S. Allocation Committee.
4. The patient **must be a full-time resident of Marion County**. If the patient's primary residence changes to outside of Marion County, all funding will immediately be ceased.
5. There must be a proven financial need, i.e. you need assistance paying for utility bills, gasoline and grocery bills.
6. The following items will be considered for assistance, Mortgage/Rent, electric, natural gas, water, gasoline and grocery bills. **WE DO NOT ASSIST WITH MEDICATIONS AND/OR MEDICAL BILLS, NOR CABLE OR CELLULAR TELEPHONE BILLS.**
7. The H.U.G.S. Allocations Committee reserves the right to provide a certain dollar amount of assistance for 90 days.
8. All applications **SHALL** be submitted through e-mail to **hugsallocations@hotmail.com**. If you are unable to e-mail the application personally, please contact your oncologist office for assistance or mail to H.U.G.S Allocations, P.O. Box 34, Ocala, Fl. 34478

B. Rules and Responsibilities for the applicant:

1. **Both pages of the application must be filled out completely.**
2. **Applicant shall provide a letter from their oncology provider showing they are in treatment for cancer.**
3. **Applicants shall provide information of organizations (contact name/number/results) that they have contacted (this will be verified through a network of non-profits).**
4. **Applicant may submit a current bill and H.U.G.S. shall make payment to Payee after applicant has been approved for assistance.**
5. **Applicants will be required to provide any additional information and documentation requested by the H.U.G.S Allocations Committee during and after application process. If applicant does not provide the information and documentation as requested for funding MAY be declined at that time and in the future.**
6. **Applicants/Recipients are required to notify the H.U.G.S. Allocations Committee of any changes of status which will affect the assistance at the time it occurs (i.e. the patient goes into remission).**
7. **Household members on the below application refers to anyone living in the residence to include roommates, room renters, etc.**
8. **If there is anything further you feel you need to explain, please write a letter on a separate sheet of paper, PLEASE KEEP ALL PAGES 1 SIDED.**

C. Duties of the H.U.G.S. Allocation Committee to the applicant:

1. Assistance will be provided according to the need and availability of funds.
2. The H.U.G.S. Charities Allocations Committee is committed to providing equal consideration to all applicants without regard to age, race, color, disability, religion, gender or national origin.
3. Assistance shall be approved at the discretion of the H.U.G.S. Allocations Committee.
4. The H.U.G.S. Allocation Committee may withdraw assistance at any time without explanation to the Applicant/Recipient.
5. The H.U.G.S. Allocations Committee will meet as needed to discuss pending applications.
6. **IMPORTANT - Please allow for up to 41 days for your application to be answered. If you do not hear anything within 7 to 10 days, contact HUGSALLOCATIONS@HOTMAIL.COM. Please keep this in mind with your bill due dates.**

February 8, 2016

REQUEST FOR ASSISTANCE WITH EVERYDAY EXPENSES FOR CHILD

REQUEST #:________________

PREVIOUS REQUEST #'S:_______________

Patient Name: _________________________________ Date of Birth: ______________

Applicant Name: __________________________________

Relationship to Patient: _____________________

Address (Street, City, County, State):____

E-Mail Address: ______________________________________ Phone #:______________

Diagnosis: ______________________________________ Date of Diagnosis: ________

# of adults in household:____ # of persons under 18 (dependents) in household:______

# of household members working:______

Marital state of child patient's caregiver: ______________________

Mother/Guardian's Employer:__________________________ Net Monthly Income:$________

Is mother/guardian on unpaid leave: YES/NO

Father/Guardian's Employer: ___________________________ Net Monthly Income: $________

Is Father/Guardian on unpaid leave: YES/NO

Do you receive any of the following and if so, how much per month: SSI/Disability: $________

Food Stamps: $_______ Alimony/Child Support: $___________ Unemployment: $_________

Other income: $________ FROM WHAT: ____

Total monthly income (all household members) including government assistance: $__________

Total monthly bills: $______________(Housing, Utilities, Insurances, etc.)

Have you received assistance from other organizations and/or your own fundraising: YES/NO

If yes, please give the organization name and/or types of fundraisers and amounts:

____

____

____

Current value of checking account: $_________ Savings account: $____________

Were you in financial crisis prior to the cancer diagnosis: YES/NO

Is this your first request through H.U.G.S. Charities? YES/NO. If no, how long was your last request: ____________________________________

CANCER CENTER PROVIDER (NAME AND ADDRESS:_____________________________________

H.U.G.S. CHARITIES, INC. AND THE CANCER ALLIANCE OF MARION COUNTY

P.O. Box 34, Ocala, Fl. 34478

February 8, 2016

____

REQUEST #:_________

REQUEST FOR ASSISTANCE WITH EVERYDAY EXPENSES FOR CHILD

Please state the reason for this request for emergency financial assistance and what assistance you need, i.e. gas cards, utility bills, etc., paid:

____
____
____
____
____
____

I/We understand that our participation in the H.U.G.S CHARITIES, INC. (H.U.G.S) AND THE CANCER ALLIANCE OF MARION COUNTY is voluntary and these benefits are a humanitarian endeavor to provide financial support and assistance to patients and patient's families who are battling cancer who are experiencing difficulties. I/We hereby release, discharge, and agree to hold harmless H.U.G.S and The Cancer Alliance of Marion County, its officers, directors, agents, sponsors, medical advisors, volunteers and employees from all claims, demands, causes of action, present or future, whether known, anticipated or unanticipated, resulting from, arising out of, or accidental to our participation in the programs or benefits provided by H.U.G.S. and The Cancer Alliance of Marion County.

I/We release H.U.G.S. Charities Allocation Committee to verify with my cancer treatment provider that I am a patient and receiving treatment.

I hereby certify that all above information submitted and statements I have made are true and agree that any false information or misrepresentation of facts may result in the cancellation or immediate dismissal of my request. I also declare neither the patient nor members of the household use illegal narcotics and are not actively involved in criminal activity.

Parent/Guardian Signature: ____________________________________ Date: __________________

Total Amount Requested: $_________

Payment to: Company Name and Address	Amount	Purpose
____	$_____________	__________________
____	$_____________	__________________
____	$_____________	__________________

H.U.G.S. CHARITIES, INC. AND THE CANCER ALLIANCE OF MARION COUNTY
P.O. Box 34, Ocala, Fl. 34478

February 8, 2016

ATTENTION – BY SIGNING ABOVE, YOU AGREE TO HAVE YOUR APPLICATION E-MAILED TO HUGS CHARITIES AND ANY COMMITTEE MEMBERS OR HUGS BOARD MEMBER IN ORDER TO CONSIDER YOUR APPLICATION. IF ANY COMPUTER SYSTEM IS COMPRIMISED, YOU WILL NOT HOLD ANY PERSONS INVOLVED RESPONSIBLE. IF YOU DO NOT WISH TO HAVE YOUR INFORMATION E-MAILED, PLEASE CONTACT HUGSALLOCATIONS@HOTMAIL.COM.