



**The Queen of Hearts Foundation, Inc.**  
**Instructions for Applying for Financial Assistance**

**The Queen of Hearts Foundation focuses on providing financial assistance to individuals coping with the day to day challenges of surviving cancer or waiting for or recovering from transplantation.**

- 1. Acceptable expenses to submit for payment are; mortgage/rent, utilities, medical bills, and food. Any assistance awarded cannot be sent directly to the patient, therefore all invoices (originals) that are to be paid must be sent with your application.**
- 2. Applicant must complete and sign the full application and submit it with the following attachments:**
  - a. The original invoice(s) you are requesting payment of. A copy of the paid invoice and cover letter will be mailed to you.**
  - b. A statement of diagnosis signed by a physician or medical professional.**
- 3. Expenses submitted may not be more than 6 months old as of the date of submission of the application.**
- 4. Decisions on the provision of assistance will be made by The Queen of Heart's Board of Directors and Trustees. The Board of Trustees will decide on the request for assistance by voting at the next scheduled monthly meeting. The Board of Trustees has the full discretion to deny, grant, or award financial assistance for each request in whole or in part.**

- 5. If the request for assistance is urgent then the Chair of the Board of Trustees may call a vote by notifying the entire Board of Trustees via Electronic communications or phone. A minimum of three Board of Trustees members, including the Chair will constitute a voting quorum for urgent assistance. Any Board of Trustees member not responding to electronic communications or phone to cast a vote within 48 hours will be tallied as absent from the vote. The Chair of the Board of Trustees will e-mail the fully disclosed results to the entire Board of Trustees by the 4<sup>th</sup> day after the call for the urgent assistance vote.**
- 6. Assistance will not exceed One Thousand Dollars (\$1,000) per family per lifetime and will be based on availability of financial resources within The Queen of Hearts Foundation Financial Assistance Fund. The Board of Trustees may increase this amount, if they find that unique circumstances so warrant, at the complete discretion of the Board of Trustees.**
- 7. Applicants will receive a notification letter outlining whether or not the application has been approved or rejected. If your request for financial assistance is rejected, The Queen of Hearts will provide the applicant with a written summary and explanation of its decision.**
- 8. All information provided will be confidential and will only be used for the purpose of determining need and financial award.**
- 9. Applications should be mailed to:  
The Queen of Hearts Foundation, Inc.  
PO Box 835  
Hammonton, NJ 08037-0835**



The Queen of Hearts  
Foundation, Inc.

*"Support, encourage, understand"*

[www.njqueenofhearts.org](http://www.njqueenofhearts.org)

PO Box 835, Hammonton, NJ 08037-0835 866-690-5425 609-567-6460 (Fax)

**Please use this form when requesting financial assistance from The Queen of Hearts Foundation. A separate form must be filled out for each invoice to be paid. Please remember that we will make a one time pay out of \$1,000 in outstanding bills. All requests must be accompanied by original invoices and mailed, not faxed, to PO Box 835, Hammonton, NJ 08037-0835**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Requested by: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Amount Requested \$ \_\_\_\_\_

Payable to: Name \_\_\_\_\_

Send to: Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

For Office Use Only: Approved By: \_\_\_\_\_ Date: \_\_\_\_\_



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**Queen of Hearts Financial Assistance  
Patient Application**

**Patients must complete the Patient Information and Financial Information pages. The patient's doctor or transplant center/nurse coordinator is to complete, and sign the medical history page. All information relating to your financial assistance will be kept confidential.**

**Patient Information**

Name of Patient \_\_\_\_\_  
 Address \_\_\_\_\_ Apt. No. \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Fax Number \_\_\_\_\_ Email \_\_\_\_\_  
 Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Number of Dependents \_\_\_\_\_ Ages \_\_\_\_\_  
 Name of Spouse, Parent or Legal Guardian (circle one) \_\_\_\_\_  
 Address (If different from above) \_\_\_\_\_ Apt. No. \_\_\_\_\_  
 City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Fax Number \_\_\_\_\_ Email \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Are you a Legal Resident of the US? Yes \_\_\_\_\_ No \_\_\_\_\_

**Employment Information**

Are you Currently Employed? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If no, how long have you been Unemployed \_\_\_\_\_  
 Current Employer \_\_\_\_\_  
 Spouse's Employer \_\_\_\_\_  
 Parent/Legal Guardian's Employer \_\_\_\_\_

**Household Information**

Single Parent Household? Yes \_\_\_\_\_ No \_\_\_\_\_

**Income (monthly)**

Household Wages \_\_\_\_\_  
 Social Security \_\_\_\_\_  
 Disability \_\_\_\_\_

**Cost of Living Expenses (monthly)**

Mortgage/Rent \_\_\_\_\_  
 Utilities \_\_\_\_\_  
 Telephone \_\_\_\_\_  
 Cellular Phone \_\_\_\_\_  
 Automobile \_\_\_\_\_  
 Insurance Premiums \_\_\_\_\_  
 Other \_\_\_\_\_



**The Queen of Hearts Foundation**  
**Medical information**

Please review this patient's application to The Queen of Hearts Foundation and complete the questions below. Verification of medical information certifies this patient is a candidate for financial assistance.

**Transplant Information**

Transplant Center \_\_\_\_\_  
Name of Transplant Coordinator \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

Name of Patient \_\_\_\_\_  
Medical Diagnosis \_\_\_\_\_  
Organ(s) Needed \_\_\_\_\_  
Has the Patient been Evaluated? Yes \_\_\_ No \_\_\_  
Is this Patient on the Transplant Waiting List? Yes \_\_\_ No \_\_\_ Listing Date \_\_\_\_\_  
Was the Patient Transplanted? Yes \_\_\_ No \_\_\_ Transplant Date? \_\_\_\_\_  
Additional Medical Information (if applicable) \_\_\_\_\_  
\_\_\_\_\_

**Cancer Information**

Medical Center \_\_\_\_\_  
Name of Nurse Coordinator \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Email \_\_\_\_\_

Name of Patient \_\_\_\_\_  
Medical Diagnosis \_\_\_\_\_  
Type of Cancer \_\_\_\_\_ Primary Site \_\_\_\_\_  
Is Patient Currently Receiving Treatments? Yes \_\_\_ No \_\_\_ Start Date \_\_\_\_\_  
If Patients has finished Treatments what was the Ending Date \_\_\_\_\_  
Additional Medical Information (if applicable) \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Coordinator

\_\_\_\_\_  
Date

