



The mission of **Kelly's Dream**, a non-profit 501(c)(3) foundation is to help ease the financial and emotional strain of cancer, raise awareness of the risks associated with melanoma; and spread the gift of hope.

Funds raised by Kelly's Dream allow us to offer limited financial assistance to patients for practical living expenses that have suddenly become too difficult to pay when an individual is undergoing treatment for cancer. We offer assistance up to \$300 per year for non-medical expenses such as the cost of transportation to and from treatment, food, childcare, utilities and other daily living expenses. Families may be provided with gift cards, have expenses paid directly to the service provider or helped through one of our local partners such as Movable Feast.

Applications are considered on a case-by-case basis, and determined on a number of factors including but not limited to:

- have a diagnosis of cancer as confirmed by an oncology health care provider
- currently in active treatment
- live in Maryland
- have an immediate financial need that is interfering with treatment plan

Steps for Applying:

1. Submit a completed Application for Assistance. Please:
 - **Print clearly** - illegible applications cannot be processed.
 - **Fill in each blank space** in the application. Use "no", "none", or "0" as appropriate.
 - **Have a medical oncology health care provider** complete the Medical Certification Form and provide a signature and date. **You cannot complete this section.**
 - **Obtain bills or receipts to support this request.**
 - **Obtain documentation showing a reduction of income** - such as pay stubs or notice from employer -or - a copy of your approval into the Critical Medical Needs Program (CMNP).
 - **Submit the Application for Assistance, Medical Information form along with documentation.** (receipts, bills and pay stubs) to **Kelly's Dream, PO Box 36, Perry Hall, MD 21128** or email it to kelly@kellysdream.org.
 - **Please Sign and Date at the bottom of every page.**
2. Applications are reviewed as soon as administratively possible, and all individuals receive an email or letter notifying the outcome. If additional information is needed, an associate or partner of Kelly's Dream will contact you.

Approval for assistance is based on the sole discretion of Kelly's Dream.

for office use:	Date:
Received:	Granted:
Additional:	Notes:



Name: _____ Phone: _____

Email: _____ County: _____

Address: _____

City: _____ State: _____ Zip: _____

Diagnosis: _____ Cancer Treatment Center: _____

Physician: _____ Physician's Phone: _____

A. Are you in active treatment? Yes No

B. Please tell us a little about your situation. Additional space on the back of page, if needed.

C. Please tell us about the assistance you need, including the cost for this service.

D. What other resources / organizations have you contacted for assistance? What was received?

E. How did you hear about Kelly's Dream?

Web Search/Social Media Social Worker/Navigator Friend/Family: Name _____

American Cancer Society Susan G. Komen Other: _____

F. **Demographic information:** Kelly's Dream collects demographical information about the individuals it supports (a) to let donors know how their gifts are used and (b) to meet any reporting that may be required for funding. Information is used in summary and NO personal information except for county or zip code will be released. This section is optional.

Marital Status: Single Married Widowed

Sex: Male Female

Age: Under 30 30-45 46-55 Over 55

Race: Black / African American White Hispanic Other



I certify that all answers provided in this application are true, accurate and complete. I have not withheld any fact or circumstance – which could, if disclosed affect my application unfavorably. I understand that by signing this document, I understand additional information may be required to confirm my eligibility for assistance. I further allow Kelly's Dream to confirm the information as needed for the purpose of providing assistance.

Signature: _____ Date: _____

Submit your application and supporting documentation to:

**Kelly's Dream, PO Box 36, Perry Hall, MD 21128
or Email it to kelly@kellysdream.org**



MEDICAL CERTIFICATION FORM

Patient Name: _____

The individual shown above has requested assistance from Kelly's Dream, a non-profit 501(c)(3) foundation whose mission is to help ease the financial and emotional strain of cancer, raise awareness of the risks associated with melanoma; and spread the gift of hope.

To be eligible, the individual must live in Maryland and:

- have a diagnosis of cancer as confirmed by an oncology health care provider
- currently in active treatment for melanoma or other cancers

As part of the application process, Kelly's Dream is requesting that a Physician or Healthcare Provider confirm the cancer diagnosis by completing this form.

I hereby certify that _____ (patient name) is currently under my care.

Physician or Healthcare Provider's Name: _____

Current Diagnosis: _____

Is the patient currently in active treatment: Yes No

Cancer Treatment Center: _____

Physician's Phone: _____

Email: _____

Office Address: _____

City: _____ **State:** _____ **Zip:** _____

Physician Signature: _____ **Date:** _____