Needs Beyond Medicine Relief Program Application — 2026

Program Overview

Needs Beyond Medicine's Relief Program provides financial assistance to individuals undergoing active cancer treatment. Grants support essential non-medical living expenses including groceries, transportation, rent, and utilities, helping relieve financial burdens during a critical time.

Applicants must be current Utah residents.

Eligibility Requirements

To be considered, all applicants must:

- Be undergoing active cancer treatment (verified separately).
- Submit a complete application.
- Provide a signed letter from an oncology nurse, doctor, or social worker verifying cancer diagnosis, current treatment plan, and financial need.

Applications with missing components will not be reviewed.

Applicant Acknowledgment

By submitting this application, I confirm the following:

- All information and documentation provided are complete and accurate to the best of my knowledge.
- Funds received from Needs Beyond Medicine will be used solely for essential living expenses outlined in the application.
- **I will reside at the address listed on this application for at least 60 days to receive funds via the United States Postal Service.**
- I understand that the status of my application will be communicated via phone or email **(applicants do not need to contact the organization, this may result in disqualification of application).**
- All information submitted will be treated as confidential and used solely for application evaluation.

I have read and agree to the above terms and confirm that the mailing address provided is accurate.

Applicant Signature: _____ Date: ___ / ___ / _____

Applicant Information

1. Full Name: _____
2. Address: _____
3. City, State, Zip: _____
4. County: _____
5. Date of Birth: _____/_____/_____
6. Gender:
   __ Female
   __ Male
7. Phone Number: _____
8. Email: _____
9. Marital Status:
   __ Single (never married)
   __ Married
   __ Widowed
   __ Separated
   __ Divorced
10. Household size (including yourself, spouse, and all dependents): _____
11. Race:
    __ American Indian or Alaska Native
    __ Asian
    __ Black
    __ Caucasian (White)
    __ Hispanic/Latina/o/Spanish Origin
    __ Native Hawaiian or Pacific Islander
    __ Other (specify) _____

Employment & Financial Information

12. Annual Household Income Earned in the last 12 months?
    __ $0
    __ $1,000-$19,999
    __ $20,000- $39,999
    __ $40,000- $59,999
    __ $60,000- $79,999
    __ $80,000- $99,999
    __ $100,00 and above

13. If applicable, name of your employer: _____

14. Current Employment Status:
    __ Full Time
    __ Part Time
    __ Self- employed
    __ Unemployed
    __ Unable to work
    __ Homemaker
    __ Student
    __ Retired

15. Do you currently have medical insurance?
    __ Yes
    __ No
16. If yes, what is the name of your medical insurance provider? _____

17. What is your Military Status (Mark all that apply)
    __ Active Duty
    __ Retired Military
    __ Are you eligible for VA benefits
    __ Not in the military or a retired veteran

18. Do you have housing?
    __ Yes
    __ No
19. If yes, is it:
    __ Rent
    __ Owned
    __ Subsidized housing

Relief Program Request Details

20. Requested Grant Amount (up to $575): $ _____

Purpose of Assistance (check all that apply, with dollar amount requested):
☐ Rent/Mortgage $_____
☐ Transportation/Gas $_____
☐ Groceries $_____
☐ Utilities $_____
☐ Other (please describe): _____ $_____

21. Have you previously received assistance from Needs Beyond Medicine? ___ Yes ___ No
If yes, when? Month/Year: _____

Describe your current situation and why financial assistance is needed: (**MUST BE ANSWERED)**

_____

_____

_____

_____

_____

_____

_____

_____

22. **Cancer Diagnosis & Treatment** (To be filled out by the applicant; verification required by healthcare provider separately)

23. **Primary Cancer Diagnosis:** _____
Stage of Cancer: ☐ Stage 1 ☐ Stage 2 ☐ Stage 3 ☐ Stage 4

Date of Original Diagnosis: ____ / ____ / _____
Is this a recurrence? ☐ Yes ☐ No If yes, recurrence date: ____ / ____ / _____

Are you currently in active treatment? ☐ Yes ☐ No
Date Treatment Began: ____ / ____ / _____

Treatments Received in Past 12 Months (check all that apply):
☐ Chemotherapy
☐ Radiation
☐ Immunotherapy
☐ Palliative Care
☐ Surgery
☐ Bone Marrow/Stem Cell Transplant
☐ Other: _____

Facility Receiving Treatment At: _____

Name and Title of Person Completing This Section

- Name:_____
- Phone: _____
- Email Address:_____
- Relationship to Applicant: □ Doctor □ Nurse □ Social Worker □ Hospital Patient Navigator
- Hospital/Clinic Name:_____ MD Name: _____

Signature of Medical Professional:_____ **Date:** ____ / ____ / _____

Required Verification (TO BE SUBMITTED WITH COMPLETED APPLICATION)
Please include a signed letter on official letterhead from your doctor, nurse, or hospital social worker confirming:
- Your current cancer diagnosis and stage
- Your active treatment plan

Application Review Timeline and Notification

- Applications are reviewed during the second week of each month.
- Due to the high volume of submissions, applicants will not be notified regarding the status of their application, whether approved or denied.
- Only selected recipients will be contacted.
- **Incomplete applications or those missing the required verification letter will not be considered for review.**

I have read the entire paragraph above and understand the timeline and review process of my application.

Applicant Signature: _____ Date: ____ / ____ / _____

Mail Completed Application & Supporting Documentation To:

Needs Beyond Medicine
P.O. Box 712043
Salt Lake City, UT 84171