THE QUALITY OF LIFE FUND
APPLICATION GUIDELINES

MISSION STATEMENT:
The Quality of Life Fund's mission is to improve the lives of people living with cancer, including patients, survivors, families and caregivers living in Aspen to Parachute and Battlement Mesa communities.

QUALITY OF LIFE FUND:
The Quality of Life Fund partners with Aspen Valley Hospital, Valley View Hospital and Grand River Health.

TYPE OF ASSISTANCE PROVIDED:
The Quality of Life Fund provides *emergency financial assistance* to mitigate the financial burden that often accompanies a cancer diagnosis.

Financial assistance is provided for current bills such as rent, mortgage, utilities (phone, electric, gas, water) car payments, insurance (home, car, health), travel expenses associated with treatment, caregiver respite, home healthcare items and services, and complementary and alternative care. In general, the fund will not be used for payment of medical procedures or medications. Dental and alternative therapies will be considered.

Each application will be reviewed and funded separately and confidentially.

There is a maximum of a $4,500 award for each application in any twelve-month period, and a lifetime maximum of $13,500.

APPLICATION REQUIREMENTS

- Applicants must have lived in Aspen to Parachute/Battlement Mesa communities for at least 1 year.
- Household monthly expenses should exceed household monthly income.
- Household should have less than $15,000 in cash assets.
- Applicants can apply for assistance for up to 3 years after they are in remission.

1. Complete application in its entirety including signature and date.
2. Attach legible copy of Driver's License or other State or Federal Issued ID.
3. Attach 'Proof of Residency' if address differs to address on ID (utility bill, lease, medical bill).

Applicants will be notified when the application is approved or denied by the review committee.

4. If the application is approved, QOL will need current bills for payment. Bills should show applicants name, vendor name, vendor mailing address, account number, amount, and due date.

Processing, payment, and delivery of bill payments takes 2-3 weeks from receipt of bills.
Checks will be mailed directly to the vendor.
No payments shall be made for services currently provided by a government agency.

Submit completed application to:
Email: qualityoflifefund@gmail.com
OR mail to:
The Quality of Life Fund
c/o Deidre Hull
PO Box 336. Aspen CO, 81612
Phone: 970-661-3162

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LIVED IN ASPEN-PARACHUTE AREA FOR MINIMUM OF A YEAR: ☐ YES ☐NO. If No, stop here.

PRIOR APPLICANT/ RECIPIENT: ☐ YES ☐NO

NAME OF APPLICANT: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

MAILING ADDRESS (if different from above): _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL: _____

MEDICAL CANCER DIAGNOSIS: _____DATE:_____

PRIMARY CARE PROVIDER and PHONE #: _____

ONCOLOGIST and PHONE #:_____

I, _____, give permission to The Quality of Life Fund Administrator, or their designee, to speak with my physicians, nurses, and other caregivers regarding this application for financial assistance.

Applicant Signature:_____ Date:_____

REFERRAL BY SOCIAL WORKER OR MEDICAL PROFESSIONAL

(Confirming diagnosis and financial need)

NAME:_____ TITLE:_____

ORGANIZATION:_____ EMAIL:_____

SIGNATURE:_____ DATE:_____ PHONE: _____

List the 'Use of Funds' or 'Vendor', and $ amount you are seeking (attach a separate sheet if needed).
Example: Rent Estimated $3,000. Utilities Estimated $1,500. Total $4,500

Use of Funds or Vendor	**Estimated Amount**
_____	$_____
_____	$_____
_____	$_____
_____	$_____

TOTAL ASSISTANCE APPLYING FOR (Annual Maximum, $4,500): **$**_____

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FINANCIAL INFORMATION SHEET

Are you currently employed? YES NO
Number of people in household: _____ Number of dependents: _____

MONTHLY HOUSEHOLD INCOME (Include spouse/partner if applicable):

Wages $_____ Social Security $_____ Pension $_____
Disability $_____ Unemployment $_____ Alimony/Child Support $_____
Medicare $_____ Medicaid $_____ CHP+ $_____
Social Security Insurance (SSI/SSDI) $_____ WIC $_____
Colorado Indigent Care Program (CICP) $_____ Support from other Funds $_____
Other–specify _____ $_____
Other–specify _____ $_____

TOTAL MONTHLY HOUSEHOLD INCOME: $_____

MONTHLY HOUSEHOLD EXPENSES (Include spouse/partner if applicable):

Rent/Mortgage $_____ Renter/Homeowners Insurance $_____
HOA Dues $_____ Electric Bill $_____ Gas/Heat Bill $_____
Water/Sewer $_____ Cable/TV $_____ Phone $_____
Auto Loan Payments $_____ Auto Insurance $_____ Auto Gas $_____
Health Insurance $_____ Groceries/Toiletries (Grocery Store) $_____
Alimony/Child Support $_____ Childcare $_____
Medical $_____ Prescriptions $_____
Other–specify _____ $_____
Other–specify _____ $_____

TOTAL MONTHLY HOUSEHOLD EXPENSES: $_____

HOUSEHOLD CASH ASSETS:

Bank Accounts $_____ Money Market $_____ CD $_____
Other – specify _____ $_____ Other – specify _____ $_____

TOTAL HOUSEHOLD CASH ASSETS: $_____

I certify that all of the information provided on this application and the supporting documentation is true to the best of my knowledge. I understand that if I falsify information, my application may be denied or may result in legal action to recoup funding. I also understand that while The Quality of Life Fund provides financial assistance working in partnership with Aspen Valley Hospital, Valley View Hospital and Grand River Health, these organizations are in no way responsible for the treatments, services or products provided by the fund or for any injuries or illnesses that might result from such services, products, or treatments. I release The Quality of Life Fund from any and all liability associated with any assistance or information provided.

Applicant Signature: _____ Date: _____