ASTERA FOUNDATION

629 Cranbury Road - Floor 2
East Brunswick, NJ 08816
Phone: (971) 900-HOPE (4673)
Fax: 732-390-7725 ATTN: Astera Foundation

Grant Application

Our Mission:
At Astera Foundation, we are committed to providing crucial financial support to patients affected by cancer diagnosis, helping them manage essential non-medical and household expenses during their cancer journey. Our goal is to alleviate the financial stress associated with a cancer diagnosis, allowing patients and their families to focus on healing and recovery.

Our Vision:
We envision a world where every family affected by cancer experiences hope and relief through our efforts, fostering a community of support and compassion.

Our Core Values:
- **Integrity:** Upholding the highest ethical standards in all our actions.
- **Support:** Offering much needed assistance to families in need.
- **Accountability:** Ensuring transparency and responsibility in our operations.
- **Compassion:** Providing empathic and heartfelt care to every patient we serve.

Funding Details:
Astera Foundation provides up to $1500 in financial assistance for household bills – in doing so, we hope to alleviate the burden associated with your cancer care and enhance your quality of life. Astera Foundation **does not** provide assistance with medical bills, credit card bills, co-payments, or subscriptions. Astera Foundation sends a check directly to the creditor; payments **are not** made directly to the applicant. All bills must be in the applicant's name. All awards are single payments and will be paid in full with no option for installments or recurring payments. All bills must be currently owed or in arrears; no payment can be made in advance. Astera Foundation is not considered an emergency fund and cannot guarantee that payments will be made by a certain date*. Astera Foundation reserves the right to suspend grant allocations based on available resources.

Eligibility:
- Must be 18 years of age or older
- Must be a legal resident of New Jersey (out-of-state assistance may be available on a case-by-case basis)
- Must have a cancer diagnosis and either be undergoing active treatment or completed treatment within the most recent six months at the time of referral, such as chemotherapy, radiation, immunotherapy, or stem cell therapy. Families who have had a recent bone marrow transplant or recent cancer surgery, or who are receiving hospice care can be referred for assistance.
- Must have an annual household income at or below 400% Federal Poverty Limit

2024 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA		
Household Size	**Federal Poverty Guideline**	**Maximum Household Income**
1	$15,060	$60,240
2	$20,440	$81,760
3	$25,820	$103,280
4	$31,200	$124,800
5	$36,580	$146,320
6	$41,960	$167,840
7	$47,340	$189,360
8	$52,720	$210,880
For families/households with more than 8 persons, add $5,380 for each additional person.		

- Household must have no more than $20,000 total in bank accounts (checking, savings)
- Patient or spouse must not own a secondary investment property

* Astera Foundation is not liable for any late fees as a result of a missed or late payment.

Required Documentation:

- Completed and signed Astera Foundation application
- Government-issued photo ID
- A current letter from oncologist stating that you have a cancer diagnosis
- Three (3) most recent bank account statements (to include deposits, withdrawals, charges, beginning and ending balance for the period). All pages of each statement are required (ex: if page says "2 of 4", all four pages are required).
- Proof of income - please provide documents for all applicable sources of income (see examples of approved documents):
  - Two (2) most recent pay stubs
  - Copy of Social Security payments for any/all household members (retirement, SSD, SSI)
  - Copy of Workman's Compensation benefits
  - Copy of short-term, long term, or temporary disability benefits
  - Pension account statement
  - Copy of a complete record of Unemployment benefit payments
  - Copy of Veteran benefits
  - Rental income
  - Alimony/Child support
  - Proof of student status (unofficial transcript or current class schedule)

Remember to attach completed and signed application, along with all documents to:

Astera Foundation
629 Cranbury Road
East Brunswick, NJ 08816
admin@asterafoundationnj.org

FINANCIAL ASSISTANCE APPLICATION	
Today's Date:	Patient DOB (MM/DD/YYYY):
DEMOGRAPHIC INFORMATION	
First Name:	Last Name:
Street Address:	
Apt:	Do you live alone? Y/N
City/State/ZIP:	
Home Phone:	Cell Phone:
Email Address:	
Primary Language:	
If you prefer for us to communicate with a primary caretaker, please provider name, relationship, and phone number:	
Oncologist Name:	Practice Name:
If you were referred to the Astera Foundation, please provide the referral name and facility:	

HOUSEHOLD COMPOSITION

Last Name	First Name	Relationship to Patient	Age	Employment Status

Please check off which bills you would like assistance with, and attach the most recent respective bill:

- ○ Housing: Rent payment $_____
- ○ Housing: Mortgage payment $_____
- ○ Utility: Water payment $_____
- ○ Utility: Sewer payment $_____
- ○ Utility: Electric payment $_____
- ○ Phone: Cell phone $_____
- ○ Phone: Land line $_____
- ○ Cable/internet payment $_____
- ○ Car: Insurance payment $_____
- ○ Car: Lease/loan payment $_____
- ○ Insurance: Life $_____
- ○ Insurance: Homeowner $_____
- ○ Insurance: Renter $_____
- ○ Property Tax $_____
- ○ Storage Unit $_____
- ○ Other: _____ $_____

YOUR STORY

Your story: Please provide a short, personal statement about how your diagnosis has affected you and/or your family:

How would financial assistance through Astera Foundation be helpful to you and/or your household?

- ☐ I give Astera Foundation consent to share all aspects of my story **including my first name** (not last name) with third parties, **including** Online Uses.
- ☐ I give Astera Foundation consent to share my story, without my name, with third parties, **including** Online Uses.
- ☐ I give Astera Foundation consent to share all aspects of my story **including my first name** (not last name) with third parties, **excluding** Online Uses.
- ☐ I do not give Astera Foundation consent to share any aspect of my story.

Signature

Print Name

Date: _____

ATTESTATION

_____ I understand that my participation in the Astera Foundation is voluntary and that these benefits are a humanitarian endeavor to provide financial support to patients who are battling cancer and are experiencing financial difficulties.

_____ I release, discharge, and agree to hold harmless the Astera Foundation, its Board, sponsors, employees, and volunteers from all claims, demands, causes of action, present or future, whether known, anticipated, or unanticipated, resulting from arising out of or incidental to our participation in the programs or benefits provided by the Astera Foundation.

_____ I release authority to gather medical information and records requested as to my condition.

_____ I recognize that in the event checks are not received by the creditor or sent to the incorrect location based on the information I provided, the Astera Foundation is not responsible for stop payment fees incurred and they will be deducted from the allotted grant monies.

_____ I attest that the information provided is accurate and truthful. I understand that I may be required to reimburse the Astera Foundation for all or some of the monies granted, in the event that it is not.

_____ _____

Signature Print Name

Date: _____

Family members, healthcare team members, or third-party signatures will only be considered if deemed authorized representative by the patient. Signature by patient or authorized representative is mandatory to process the application. Applications will be reviewed no later than four (4) weeks after receiving the application. Applicants chosen for assistance may reapply in twelve (12) months' time. Applicants not chosen for assistance may reapply in six (6) months' time.