

## **Application for Assistance - Confidential**

To be considered for assistance through The Mary Grace Memorial Foundation, please make sure that all sections are complete and all required signatures are included. Send the completed application with the signed "Publicity Release" to the address indicated at the end of the form.

Participant's Name

\_\_\_\_\_

First

Middle

Last

Home Address: \_\_\_\_\_

Street

City

State

Zip

Home Phone: \_\_\_\_\_ Best Time to Call: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred by: \_\_\_\_\_

### **Medical Information**

Please attach a copy of your pathology report for verification purposes.

Physician's Name: \_\_\_\_\_ Facility: \_\_\_\_\_

Phone: \_\_\_\_\_

Nurse/ Social Worker: \_\_\_\_\_ Facility: \_\_\_\_\_

Phone: \_\_\_\_\_





Please read and sign below. Make sure to have your signature witnessed and dated.

I understand and agree that no promises or assurances whatsoever have been made to me by any representative of The Mary Grace Memorial Foundation regarding the assistance I am requesting.

I understand and grant my permission to all my doctors, clinics and hospitals to provide information to The Mary Grace Memorial Foundation relating to any treatment and care for cancer and other related health problems when necessary. The Foundation agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission.

I understand and agree that fulfillment of assistance may result in publicity whether or not The Mary Grace Memorial Foundation actively takes steps to publicize its service.

I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by The Mary Grace Memorial Foundation.

I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of service being requested and offered.

\_\_\_\_\_  
Participant Date

\_\_\_\_\_  
Witness Date

\_\_\_\_\_  
Spouse (if participant is unable to complete) Date

Service Requested: \_\_\_\_\_

Amount Requested: \_\_\_\_\_

Please mail this form to:

The Mary Grace Memorial Foundation  
P.O. Box 1822  
Medina, Ohio 44258