Mary Grace Memorial Foundation

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

Best Phone Number to Reach You : _____ Best Time to Call: _____

Date of Birth: _____/_____/_____ Email Address:_____

Referred by: _____

If patient is a minor, name of parent or guardian: _____

Medical Information

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

Physician's Name: _____ Facility: _____

Phone: _____

Nurse/ Social Worker: _____ Facility: _____

Email Address:_____ Phone: _____

Celebrate Life

Marital Status (Check one): ___Single ___Married ___Widowed

How many persons are living in your household? (Include yourself, all adults and children): _____

Do you rent or own your home? _____

Are you currently employed? _____

Do you have health insurance? _____

____Medicaid ____Medicare ____Disability Insurance ____Other

Public or private assistance you are receiving: _____

Total after-taxes household income per year (including all persons living in household): _____

Have you in the past or are you currently receiving grants or aid from other organizations with similar missions as The Mary Grace Memorial Foundation? _____ If "yes", please indicate the name of the organization and the amount and type of grant you have received.

Needs Assessment

Please let us know how we can help you by prioritizing you needs, and the payment amount:

____ Housing - rent or mortgage payment $ _____

____ Transportation Service - needed for chemotherapy/ radiation treatments - doctors appointments $ _____

____ Utility/ Telephone bill payment $ _____

____ Other $ _____

Mary Grace Memorial Foundation

Payments are made to third parties. Please include all of the contact information below

Name of company: _____

Address: _____

Phone: _____ Contact person (if applicable): _____

Account Number associated with this payment: _____

Please include a copy of the bill(s) and the date you would like it paid

The Board has no way of knowing you except through this application. Therefore, we would like to give you space to tell us your "story" so that we might better understand your need for our assistance.
(Use reverse side or limit to one typed written page please).

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Mary Grace Memorial Foundation

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: _____

Office Use:

Date Received_____

Date Processed_____

Please mail this form to:

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

Celebrate Life