Application for Assistance – Confidential

To be considered for assistance through The Mary Grace Memorial Foundation, please fill out this application. Be sure that all sections are complete and all required signatures are included. Then, please send the completed application to the address indicated at the end of the form.

Personal Information

Today's Date *

MM DD YYYY

Name *

First Name Last Name

Address (Street, City, State, Zip) *

Phone *

(###) ### ####

Email Address *

Age *

Referred by:

If patient is minor, name of parent or guardian:

First Name Last Name

Medical Information

Physician's Name

First Name

Last Name

Facility

Physician's Phone

(###) ### ####

Nurse / Social Worker Name

First Name

Last Name

Facility

Nurse / Social Worker Email

Nurse / Social Worker Phone

(###) ### ####

Household Information

Marital Status

- [ ] Single
- [ ] Married
- [ ] Widowed

How many persons are living in your household?

Include yourself, all adults, and children:

Do you rent or own your home?

- [ ] Rent
- [ ] Own

Do you have health insurance?

- [ ] Yes
- [ ] No

If yes, check all that apply:

- [ ] Medicaid
- [ ] Medicare
- [ ] Disability Insurance
- [ ] Other

Have you received a grant from the Mary Grace Memorial Foundation in the past?

- [ ] Yes
- [ ] No

Needs Assessment

All financial assistance payments are to be made to 3rd parties (i.e. your mortgage lender). Please indicate your top 2 payments requested, in order of priority. You may request assistance with mortgage, rent, or utilities.

Payee 1 Name

Payee 1 Account Number

Payee 1 Address (Street, City, State, Zip)

Payee 1 Phone Number

(###) ### ####

Payee 1 Amount Due

Payee 1 Due Date

MM DD YYYY

Payee 1 Comments

Is there anything else you'd like to communicate about this bill or payee?

Payee 2 Name

Payee 2 Account Number

Payee 2 Address (Street, City, State, Zip)

Payee 2 Phone Number

(###) ### ####

Payee 2 Amount Due

Payee 2 Due Date

MM DD YYYY

Payee 2 Comments

Is there anything else you'd like to communicate about this bill or payee?

More About You

Well, this is the big one... perhaps the most important part of your application for grant funds, as the following questions allow our Board the opportunity to get to know you as an individual. Please provide answers to the following:

First, please tell us briefly of your life leading up to your illness (relationships, home life, work life, etc.).

A cancer diagnosis can create significant disruption. Please tell us how your diagnosis has affected you, and how you are now in financial need.

Finally, describe your hopes for the future.

Please read and sign below:

Thank you for sharing your story with us. The Mary Grace Foundation exists to provide financial relief to individuals so they can focus on their own health.

When submitting this application, for verification purposes, please be sure to mail a copy of your pathology and/or medical report. (We don't need an entire medical report, but rather something dated that verifies you have been diagnosed with cancer and are actively receiving treatment.) Please also mail copies of the bill(s) for which you're requesting financial assistance. Applications cannot be processed until medical documentation and copies of bills are received.

Acknowledgments:

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 services. 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 Name (Printed) ____________________________ Participant Signature __________________________ Date: ________

Witness Name (Printed) ______________________________ Witness Signature ____________________________ Date: ________

Spouse Name* (Printed) ______________________________ Spouse Signature ____________________________ Date: ________
*(*if participant unable to complete)*

Assistance Requested:________________________________

Total Amount Requested:_____________________________

Please mail this form and supporting items to:

The Mary Grace Memorial Foundation
PO BOX #1822
Medina, Ohio 44258

Office Use Only:

Date Received: _________________

Date Processed: ________________