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 At: ______________________ Best Time to Call: _________________

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: ___________________________________

Celebrate Life

Personal and Family Information

Marital Status (Check one): ___Single ___Married ___Widowed ___Partnered

___Separated ___Divorced

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 $ ________

Payments to third parties (rent, mortgage, utilities, phone bills, etc.) are made directly to the third party. Therefore, if rent, mortgage, utilities, etc. is requested, please indicate all contact information below.

Name of company: ____

Address: ____

Phone: ____________________ Contact person (if applicable): ____________________

Account Number associated with this payment: ______________________________

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).

____

____

____

____

____

____

____

____

Celebrate Life

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