



LEGACY BRAIN FOUNDATION[®]
FIGHTING BRAIN CANCER ONE DAY AT A TIME.

Legacy Brain Foundation Grant Support Request Form

HOW ELIGIBILITY FOR GRANT ASSISTANCE IS DETERMINED

All grant assistance will be awarded by Legacy Brain Foundation based on need. Grants are awarded to patients with brain and spinal cord tumors, either primary or metastatic disease. Grant applicants may receive assistance one time in a 6 month period and may receive assistance twice in 12 months not to exceed \$2000 per calendar year.

Incomplete applications will not be reviewed until requested information is received.

Grants are limited to patients who reside within the state of Texas.

Amount requested \$ _____ (Limited to \$1000 per request)

Please state the reason for the amount requested and how it will be used. For example, if you are requesting assistance to pay COBRA payments, list the monthly cost of your COBRA insurance. If you have multiple bills that will be included in the grant request, please list them individually. _____

PATIENT INFORMATION (please print)

Name: _____ DOB _____

Address: _____

Cell Phone: _____ Home _____

Fax: _____ Email _____

Married? _____ yes _____ no List number and ages of dependents: _____

MEDICAL INFORMATION

Date of diagnosis: _____

Diagnosis: _____

Are you currently receiving treatment? yes _____ no _____

Please indicate type of treatment (chemotherapy, radiation therapy, physical therapy, etc.)

Please submit a copy of your pathology report with your application.

HEALTH CARE PROFESSIONAL INFORMATION

List one physician who is familiar with your case who can verify your diagnosis and your need for treatment. Make sure this information is accurate as verification must be obtained before your grant request can be considered.

Physician: _____

Specialty: _____

Address: _____

Office phone and fax _____

INCOME AND ASSETS

Estimate the amount currently available in your checking/savings accounts:

If you own your home, what is the current value of your home? \$ _____

Estimate Mortgage balance \$ _____

Monthly income \$ _____

Spouse monthly income? \$ _____

Monthly disability income? \$ _____

Other assets, including pension, IRA, etc. _____

Other recurring income, please list: \$ _____

Total Gross Monthly Income \$ _____

EXPENSES

Estimate your recurring monthly living expenses: Rent or house payment_____

Utilities_____ Car payment/insurance_____ Child support _____

Health Insurance_____ Other (specify)_____

Estimate your outstanding medical bills:

Hospitals_____ Diagnostic tests/Imaging_____

Doctors_____ Other medical expenses_____

Medications_____

HEALTH INSURANCE INFORMATION

Do you have health insurance? _____ Medicare? _____ Medicaid? _____

Please indicate insurance provider_____

What is the amount of current medical bills not covered by insurance or any other charitable group or foundation? \$_____

Have you applied for other types of assistance?_____

Remember that there are types of assistance that are very specific, for example, pharmaceutical company support in supplying specific drugs; co-pay assistance; hospital foundations that pay a portion of the hospital bill. The American Brain Tumor Association, Musella Foundation (virtualtrials.com), and National Brain Tumor Society list other forms of financial assistance available. Although grants from the Legacy Brain Foundation are not limited to the costs associated with medical care, grant applicants are encouraged to look for other forms of assistance specific to their needs. Please contact us if you are interested in finding other organizations which may be able to assist you.

Certification Statement

I certify that the information provided on this application is true and accurate to the best of my knowledge. I authorize the Legacy Brain Foundation to obtain from the individuals, businesses, organizations, agencies, or entities listed in this application whatever information is necessary about my cause that might be helpful for assessing my application. I release the Legacy Brain Foundation of all liabilities or claims arising out of the donation of money or services provided to me or my family.

All information in this application is strictly confidential and will be used only to ascertain eligibility for financial assistance. This information will not be released to any person or persons not associated with the Legacy Brain Foundation Grant Committee.

Patient Name (please print) _____

Signature _____ **Date** _____

Return completed document to: Legacy Brain Foundation, Attn: Grant Application, Medical City Dallas Hospital, 7777 Forest Lane Suite C-648, Dallas, Texas 75230

Or fax to 972-566-2625

Should you receive a grant from the Legacy Brain Foundation, would you be willing to provide a statement to be used in the LBF newsletter, web site, brochures, or other materials describing the mission of the Foundation? **This is strictly voluntary and will in no way affect your application. No information of any kind will be used without your consent.** Should you choose to do so, written statements, photographs, or video may be submitted by you; or you may choose to have someone from the Foundation contact you.

_____yes

_____no

_____I do not wish to answer at this time but may be open to this in the future.

_____Please contact me; would like more specific information.