Grant Application

Grant assistance is awarded by Legacy Brain Foundation based on need. Need assumes that the family unit (immediate family, husband/wife, mother/father) is responsible for a patient's care to the extent of their ability to pay and will be used to supplement the effort of the patient. Outstanding medical and non-medical expenses are taken into account in determining need. Grants are awarded to patients with brain and spinal cord tumors, either primary or metastatic. Grants are limited to patients who are residing in the state of Texas, or who are receiving treatment in the state of Texas in an ongoing relationship between a physician or an institution in Texas primarily responsible for the patient's oncology care.

Grants are made on available funds and are limited to $1,000 per request every 6 months, and not to exceed two requests per year, or a total of $2,000 per calendar year. Grants will be evaluated based on demonstrated needs or financial hardship, but priority is given to those patients who require financial assistance to continue treatment.

Please state the total amount requested and attach a copy of the bills or verification of treatment cost or expenses. Up to three bills may be included per grant and partial payment of a bill may be required if the amount requested exceeds $1,000. Requests for grants under $1,000 will not carry forward to another grant period. Families are also allowed to request funds to cover unpaid costs resulting from the death of a brain tumor patient. Grants can be paid directly to pharmacies, diagnostic imaging facilities, etc. to allow the patient to receive these services; in this case, a statement should be attached to request that funds be applied toward the patients treatment. Once payment is made to a facility, the funds cannot be redirected or refunded to the patient, but must be returned to the Legacy Brain Foundation if services are not received.

If emergency expenses are needed for food, utilities, rent or treatment costs, please note that normal processing time for grant requests are 4-6 weeks. Expedited processing can be requested by submitting your application **and** having your treating physician contact Dr. Stark-Vance at (972) 566-2622 to explain the situation.

Any misuse or redirection of funds for uses other than the immediate need of the patient, or for purposes other than those stated will be grounds for refusal for further financial assistance and may subject the person responsible to legal action.

Note: In order to process your request, you MUST complete ALL information; or write "N/A" if not applicable to your situation.

Amount Requested: ______________________________

Expenses to be covered: (**MUST** attach copies of bills or statements; no more then three. If you are requesting the grant to help with a mortgage payment, please include a copy of the payment statement that lists the recipient, address, account number, etc. to make sure it's properly credited.)

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Name: ______________________________

Address: ______________________________

Home Phone: ______________ **Work Phone:** ______________ **Cell Phone:** ______________

Fax: ______________ **Email:** ______________

Diagnosis: ____
Include a copy of your pathology report with your application (or proof of brain metastasis if you have a malignancy which has spread to the brain.)

How long have you been diagnosed with the condition? ____

Treating Physician's Name: ______________________________ **Phone Number:** ____________________
Physician will be contacted to verify the diagnosis.

Address: ____ **Fax:** ____________________

INCOME & ASSETS:

Estimated amount in savings account: _______________ **Estimated amount in checking account:** _______________

What is your monthly income? Please include salary, disability payments, and child support or alimony, if applicable.

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What is your spouse's monthly income? Include any other sources of income not counted above. ____________________

Do you have any other assets? (Stocks/bonds, IRA, pension, etc.) ____

EXPENSES:

Current Value of Home: ____________________ **Monthly Mortgage Payment:** ____________________

OR - **Monthly Rent:** ____

State the amount you typically spend monthly for recurring expenses, if applicable:

Car Payment: ______________________________ **Car Insurance:** ______________________________

Utilities: ______________________________ **Phone/Internet:** ______________________________

Tuition: ______________________________ **Child Care/Child Support:** ______________________________

Estimate the total of medical bills NOT COVERED by insurance or any other charitable group or foundation: ______________

Please list the hospitals in which you have open (unpaid) accounts: ____

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If there are other circumstances which have created a financial need (illness if another family member, loss of job, etc.) that you would like the board to consider in reviewing your application, please explain:

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DO YOU HAVE:

Health Insurance? ☐ Yes ☐ No **Medicare?** ☐ Yes ☐ No **Medicaid?** ☐ Yes ☐ No

Healthcare Expense Account? ☐ Yes ☐ No

Please indicate insurance provider: ____

Do you currently have outstanding bills from your treating physician? ☐ Yes ☐ No

Have you applied for other types of assistance? ☐ Yes ☐ No

Remember that there are types of assistance programs 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 the 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 that 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 necessary information from the individuals, businesses, organizations, agencies or entities listed in this application that might be helpful for assessing the grant request. 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. The information will not be released to any person or persons not associated with the Legacy Brain Foundation Board unless required by law.

You may elect to be recognized as a recipient of this grant in future Legacy Brain Foundation newsletters, websites and events. Whether you choose to allow recognition as a grant recipient will not affect your eligibility in any way or compromise your ability to receive grants in the future. However, it can be helpful to other patients to know that you were successful in receiving assistance from the Legacy Brain Foundation.

☐ Yes, I agree that my name or initials may be used.

☐ No, I do not want to be identified as a recipient.

☐ Possibly, but would like to be contacted further with specific information.

Name: (please print) ____

Signature: ______________________________________ **Date:** ____________________

RETURN COMPLETED APPLICATION TO:

Legacy Brain Foundation, Attn: Grant Application
Medical City Dallas Hospital
7777 Forest Lane, Suite C-648
Dallas, TX 75230

Or fax to (972) 566-2625

CHECKLIST OF ITEMS TO BE INCLUDED WITH THIS APPLICATION:

☐ Copy of pathology report

☐ Copy of bills or expenses to be covered by this grant

☐ Treating physician's name and contact information

FOR OFFICE USE ONLY:

Date application received: ____

Verification of application/referring physician contacted: ____

Date taken to board: ____

Decision of board: ☐ Approved. Amount $ ____________________ ☐ Denied. Reason: __________________________________

Applicant notified of decision: ____

Date of check(s) and recipients(s): ____

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Has applicant previously received funds from LBF? ☐ Yes. Date:__________________________________ ☐ No.