Application for Assistance (for brain cancer patients) - Confidential

To be considered for assistance through Misssion4Maureen, please make sure that all sections are complete and all requested signatures are included. Send all required pages to the address listed at the bottom of page 3.

Patient's Name

____

First Middle Last

Home Address: ____

Street City State Zip

Home Phone: ________________________ Best time to Call: _____________________________

Work Phone: _________________________ Date of Birth: ______/______/__________

Email:______________________________ 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: _____________________________

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): _____

Are you currently employed? _______________

Do you have health insurance? ____Private/Employer Insurance (Level of deductible_______________)

____Medicaid ____Medicare ____Disability Insurance ____None

Total after tax household income per year (including all persons living in household): _________________

Net Worth

Mission4Maureen is a tax-exempt, non-profit foundation. As such, Mission4Maureen may engage only in those activities, which are charitable in nature. Mission4Maureen may provide grants to individuals to "provide financial relief " or to aid individuals in "distress." The information, which you provide, on this Net Worth Statement will be used exclusively by the foundation to determine your eligibility for financial assistance. The foundation will not disseminate or release the provided information to outside sources without first obtaining your prior express consent. The following financial information is being submitted by the applicant in consideration of possible financial assistance.

The following figures are accurate as of ______________________, ____

(Date) **(Patient or representative's signature)**

I. **Assets:**

A. **Liquid Assets:**	**Current Value**
Cash on Hand…………………………………………	$_____________
Checking Account…………………………………………….	$_____________
Savings Account……………………………………………..	$_____________
Other Liquid Assets……………………………………	$_____________
TOTAL…………….	$_____________

C. **Fixed Assets:**	**Current Value**
Value of Principal Residence………………………………………	$_____________
Equity in Principal Residence………………………………………	$_____________
Automobile(s) Personal Property…………………………………….	$_____________
Other Fixed Assets…………………………………………………..	$_____________
TOTAL………………..	$_____________

II. **Liabilities:**	**Total Current Value**	**Monthly Payment**
Student Loans……………………	$____________________	$____________________
Mortgage(s) (Principal residence, Excluding Real Estate Taxes)……	$____________________	$____________________
OR Rent paid…………………………………………………….		$____________________
Personal Lines of Credit………….	$____________________	$____________________
Auto Loan/ Lease payments……	$____________________	$____________________
Home Equity Loan……………….	$____________________	$____________________
Real Estate Taxes Due……………	$____________________	$____________________
Income Taxes Due……………….	$____________________	$____________________
Credit Card Debt………………..	$____________________	$____________________
Other Liabilities & Expenses…….	$____________________	$____________________
TOTAL………	$_____________________	$____________________

The Board has no way of knowing you except through this application.
Therefore, we would like you to tell us your "story" and include a photo of yourself (or family) so that we might better understand your need for our assistance. Please attach a photo and a one page, typed or printed story to your application.
Photographs will be returned.

Medical Release

Please read and sign below. Make sure to have your signature witnessed and dated.
I understand and grant my permission to all my doctors, social workers, clinics and hospitals to release all healthcare and billing information relating to my treatment and care for brain cancer and other related health problems to the Mission4Maureen foundation.
I also grant my permission to discuss the above information with any designated representative of Mission4Maureen by phone.
(mail: Mission4Maureen, P.O. Box 21602, S. Euclid, OH 44121 – fax: #440-442-8895 phone: # 440-840-6497)
Mission4Maureen 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 specifically authorize the release of all my healthcare and billing information in your organization's possession. The purpose of my request is to assist Mission4 Maureen in determining my eligibility for financial assistance. This Release and Authorization shall expire twelve (12) months from its execution if not revoked prior thereto. Mission4 Maureen will not disseminate or release these medical records to any outside source without first obtaining prior express consent. I understand and agree that fulfillment of assistance may result in publicity whether or not Mission4Maureen 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 Mission4 Maureen 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. I understand and agree that no promises or assurances whatsoever have been made to me by any representatives of Mission4Maureen regarding the assistance I am requesting.

______________________________ ______________ ______________
Print Patient's Name Date of birth SSN

____
Address:

____
Patient's signature Date

____
Witness Date

____
Spouse, Parent or Guardian (if patient is unable to complete) Date

Service or Payment Requested: ____

Amount Requested:______________________________

Please note: Mission4Maureen pays companies directly from bills and/or statements received once financial assistance is approved.

Publicity Notice-Release

Mission4Maureen may hold events and fundraisers throughout the year to raise money to fund the primary objective of the foundation: to help families endure the staggering cost of brain cancer treatment. People continue to support us because they want to see their money find its way to the people who need it the most. We need your help to put a face and a name to that reality. To this end we will use your photo, your name, and your submitted story. If your application is approved, Mission4Maureen may also use a brief description of how the assistance that you received has helped you. This will facilitate communication with our donors and help in attracting more contributors. Please acknowledge this notice-release by signing below:

I hereby acknowledge that Mission4Maureen may use my name, photo, background and story in PR and marketing materials which will include, but not be limited to, its newsletters, website, mailings and general information brochures.

____
Signature of Patient, (or if patient cannot sign; Spouse, Parent or Guardian) Date

Please submit this 3-page application, your photo, your printed "story"
and a copy of your pathology report to:
Mission4Maureen, PO Box 21602, South Euclid, OH 44121