Glenn Garcelon Foundation

empowering & supporting brain tumor patients

Welcome to our Grant Application.
The Mission of the Glenn Garcelon Foundation is to empower and support brain tumor patients and their families. Our Grant Program is a vital way for us to fulfill our mission.

In addition to the application, there are other required items that need to be submitted. Applications go to the Review Committee the 25th of each month, so your application must be received in its entirety no later than the 23rd to be considered for that month (with the exception of December, when the review will be on the 15th so all items are needed no later than the 13th.

**Please add ggf@glenngarcelonfoundation.org to your contact list. We will send an email when your application is received and let you know if we need any additional items. By adding our email address to your contact list, you will ensure that our communication does not end up in your junk mail file and keep your application from moving forward in the review process.**

Please let us know if you have any questions
by emailing ggf@glenngarcelonfoundation.org by calling 503-969-7651.

## *FAQs*

Can the application be completed in another language?
Since we do not have any translators in our office, the entire application and all other required items must be completed in English.

*Do you provide grants to patients with secondary brain tumors?*
*Due to the large amount of applications we receive, we only provide assistance to those with primary brain tumors.*

*Are grants only given to those residing in certain states?*
*No, we accept applications from any of the 50 states and US territories. Applicants must reside in and be receiving treatment in the United States or its territories to be eligible.*

*What is the amount given to a qualified applicant?*
*Grants are need based and the maximum given to a qualified applicant is $1000.*

*How do I submit the grant application?*
*The completed application may be submitted in one of two ways.*
*By scanning and sending (as **PDF**) to **ggf@glenngarcelonfoundation.org***
***Screenshots are not accepted***
*By mailing the packet to Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019 (no staples)*

*When are applications reviewed?*
*Applications go to the Review Committee on the 25th of each month, with the exception of December when they are reviewed on the 15th. Your packet must be received in its entirety no later than the 23rd (13th in Dec.).*

*When will I hear if my grant has been accepted or denied?*
*We will send you an email when we receive the application. The Review Committee has a response to us within one week after they receive the packet in its entirety. You will be notified by email and mail of the decision of the Review Committee.*

*If I am awarded a grant, am I allowed to apply for additional help from the Glenn Garcelon Foundation?*
*Due to the amount of applications we receive, grant recipient can only apply for a grant once every two years (24 months).*

# Financial Assistance Application

## PERSONAL INFORMATION

***PLEASE PRINT ALL INFORMATION CLEARLY***

**FULL LEGAL name** of **patient** _____ Preferred First Name_____

Date of birth ___/___/ ___ Age _____ Gender: M F Patient Phone number(s) _____

Mailing Address _____

Street Address (if different) _____

City, State, Zip Code _____

Email address of **patient** _____

Spouse/significant other's name _____

Spouse/SO phone number _____ Spouse/SO email _____

If patient is a minor, Names of parents/guardian _____

If patient is a minor, Email addresses AND Phone numbers of parents/guardian _____

Name of relative (not living with you) _____ Relationship _____

Email **and** Phone number of relative _____

Address of relative _____

Does the patient have health insurance? Yes No If applicable, annual deductible amount _____

If you have health insurance, please indicate type of insurance (circle all that apply):

Private Medicaid Medicare Medicare+ Medigap VA program Other (specify) _____

If private insurance, company name _____

***I certify that the information contained on this page is true and accurate.***

_____ _____

Printed name of person completing application Signature of person completing application

Relationship to Patient? Self Spouse Family Member/Caregiver Health Care Professional

If someone other than the patient, parent, spouse or health care provider completes this application, we will need a notarized Power of Attorney specific to the state you reside in, in order for us to discuss this patient and the grant application with you.

**GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE**

**PATIENT NAME**_____

## FINANCIAL INFORMATION

Is **patient** currently employed? Yes No If employed, employer's name _____

Spouse's or significant other's employer _____

If patient is a minor, parent/guardian employer's name _____

Number of people in household _____ Ages _____Number of employed people in household _____

If there are unemployed adults in the home, other than patients, why are they unemployed? _____

### INCOME

Total Annual Income **for all living in the household** _____

Checking Account Balance _____ Savings Account Balance _____ Bank Name _____

Family Income Sources (check/circle all that apply)

Salary Pension Social Security Unemployment Short-Term Disability SSD Disability

SSI Public Assistance Family/Friends Other (specify)_____

List the names of all other organizations and foundations that you have applied to for financial assistance. If you received assistance, please note next to the organization's name, how much you received and when. If a GoFundMe page or other fundraiser has been held to assist you, please include that information. (use a separate sheet, if necessary)

_____

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### EXPENSES

Monthly Rent/Mortgage _____ Monthly Utility Bill _____ Monthly Phone/Cable/Internet _____

Number of Vehicles in Household? _____ Automobile Monthly Payment(s) _____

Monthly Insurance (auto, homeowners, life) _____ Credit Card balance _____

Medical Bills(s) Balance _____ Loan(s) Type & Balance _____

Other (be specific) _____

**I certify that the information contained on this page is true and accurate.**

_____ _____

Signature of applicant or guardian date

**GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE**

 **PATIENT NAME**_____

## ADDITIONAL REQUIRED AND OPTIONAL ITEMS TO BE SUBMITTED WITH APPLICATION

**Your application cannot be forwarded to the Review Committee until we receive the completed application, as well as the following required items.**

**REQUIRED ITEMS:**

- **PROOF OF INCOME** (in **PDF** format)
  - First two pages of **signed copy of 1040 income tax return for the past 2 years** (blacken out social security numbers) OR if you do not file tax returns: please submit 6 months' worth of copies of pay checks/stubs, unemployment checks, or SSI, SSD, public assistance benefit notifications for all members of household.
  - If patient is a minor, financial records of parent/guardian need to be submitted.
  - **All income earners in household need to submit these items**.

- **BILLS** (in **PDF** format)
  - Copies of current bills that you are requesting to be paid. Must include account number and mailing address of vendor. **Please prioritize which bills are most crucial to receive help with**.
  - Checks are not issued to the applicant. They will be sent directly to the company you have requested payment to (rent, mortgage, medical bills, utilities, etc.). Thus, we will need copies of those bills that include the account number and mailing address.
  - If you are requesting help with rent, submit a copy of your rental lease that includes your name, amount of rent, landlord's name and mailing address where payments are made.

- **MEDICAL REPORTS** (in **PDF** format)
  - Copy of pathology report, if you have had biopsy/surgery.
  - Copy of most recent MRI report (not MRI scan)

**OPTIONAL ITEMS:**

- **PHOTOS** (in **JPG** or **PNG** format)
  - Please submit **several** high quality pictures in **jpg** format. High quality photos are imperative as they will be placed on our website, and perhaps at fundraising events, in promotional materials and/or in meetings with potentials donors/sponsors. Scanned pictures will not be high quality enough, so if emailing, please attach to email. If sent separate from application, please send them digitally in jpg format to **ggf@glenngarcelonfoundation.org** and put your name in the subject line. Note: we do not want photos of your head following surgery.
  - We are unable to return photos to you, so be sure to only send those you have duplicates of.

- **PERSONAL STORY** (in **PDF** format)
  - On a separate sheet of paper, please tell about you, so that we may get to know more about. **We want to know about you**: career, interests, family, what life was like both before and since your diagnosis, etc.

- **TESTIMONIAL** (in **PDF** format)
  - Have a family member or close friend tell us about you. We want to get to know you from someone else's perspective. (please **DO NOT** have them write about your brain tumor journey)

**Please initial your choice: If I am awarded a grant, I _____ DO _____ DO NOT agree to allow my story, a brief history of my brain tumor journey, and my picture to be used on the Glenn Garcelon Foundation website, at fundraising events, and as needed to further the mission of the Foundation.**

_____ _____

Signature of applicant or guardian date

**GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE**

 PATIENT NAME_____

## MEDICAL INFORMATION

## TO BE PROVIDED BY APPLICANT/PATIENT

Date of diagnosis _____ If this is a recurrence, date of original diagnosis _____

Neurosurgeon's or doctor's **name (REQUIRED)** _____

Social Worker's /Patient Advocate **name and phone number and email** (REQUIRED)

_____

Oncologist's **name (if applicable)** _____

Hospital where receiving treatment(s)_____

## DEMOGRAPHICS

(Your responses are private and will only be used for our records. They will **not** be used to determine your eligibility for a grant.)

**What is applicant's ethnic origin?**

- ☐ African American/Black
- ☐ Arab American
- ☐ Asian
- ☐ Hawaiian/Pacific Islander
- ☐ Latino/Latina/Latinx
- ☐ Multiracial
- ☐ Native American/Indigenous
- ☐ South Asian
- ☐ White/Caucasian
- ☐ Other (please specify) _____

**What is applicant's age?**

- ☐ Under 10 years old
- ☐ 10-17 years old
- ☐ 18-25 years old
- ☐ 26-35 years old
- ☐ 36-48 years old
- ☐ 48-54 years old
- ☐ 55-64 years old
- ☐ 65-74 years old
- ☐ 75 years or older

**What is applicant's marital status?**

- ☐ Married
- ☐ Domestic Partnership
- ☐ Divorced
- ☐ Separated
- ☐ Single, never married
- ☐ Widowed

**What is applicant's gender?**

- ☐ Man
- ☐ Woman
- ☐ Non-binary (neither, both or something else) Please specify _____

**How did you learn about the Glenn Garcelon Foundation**?

☐ friend ☐ website ☐ news article ☐ doctor/social worker ☐ web search ☐ social media ☐ event ☐ other_____

**I certify that the information on this page is true and accurate.**

_____ _____

Signature of applicant or guardian date

revised 11.2.21

_____

**Patient signature**

**I give permission for my doctor(s) to provide information and reports about my medical condition and treatment to the Glenn Garcelon Foundation. Further, I give permission to hospital personnel to provide additional information about my needs to the Glenn Garcelon Foundation. I certify that neither I nor anyone other than a medical professional treating me for my brain tumor completed ANY part of this page other than my signature above.**

## *MEDICAL PERSONNEL REPORT*

**This section can ONLY be completed by your oncologist, neurosurgeon, neurologist (or a nurse in one of those offices), social worker or other health care professional treating you for your brain tumor.**

Patient Name _____

Date of Diagnosis: _____ Type of brain tumor _____ WHO Grade _____

Circle one: benign malignant unknown at this time Primary brain tumor? Yes No

If secondary, location of primary cancer?_____Recurrence? Yes No

Is patient in active treatment? Yes No If not in active treatment, how often do you see the patient? _____

Please indicate type(s) of treatment(s) patient has received (circle all that apply)

Chemotherapy Radiation MRI Surgery Palliative care

Bone marrow/stem cell transplant Other (specify) _____

Please indicate type(s) of treatment(s) patient might need in the future (circle all that apply)

Chemotherapy Radiation MRI Surgery Palliative care

Bone marrow/stem cell transplant Other (specify) _____

In your opinion, is the patient able to work at this time (if a minor, is parent unable to work due to caregiving responsibilities)? _____

**HEALTH CARE PROFESSIONAL INFORMATION** (please print)

Doctor's name:_____Hospital/Clinic: _____

Address City, State, Zip _____

Phone: _____ Fax: _____

**Name and Title** of person completing this section, if different than above (please print)

_____

Phone_____Email: _____

Your relationship to person applying for help: Doctor Nurse Social Worker Other _____

_____ _____

Signature of Medical Professional Date

**PLEASE WRITE A SHORT STATEMENT ON THE PATIENT'S MEDICAL CONDITION AND YOUR FINANCIAL NEEDS ASSESSMENT OF THIS PATIENT OR ATTACH LETTERHEAD OR ENVELOPE ASSOCIATED WITH THE CLINIC/HOSPITAL COMPLETING THIS PAGE.**

If you wish to speak with us, please call (503-969-7651) or email completed form to ggf@glenngarcelonfoundation.org

**All information is strictly confidential and is for Glenn Garcelon Foundation use only**

# GRANT APPLICATION CHECKLIST

Your application cannot be forwarded to the Review Committee until we have received the packet in its entirety. Be sure all parts have been completed and signed as requested. Do not use staples or tape on any pages.

We will contact you via email if additional information is needed, so be sure to ADD **ggf@glenngarcelonfoundation.org** to your contact list. Once your application has been reviewed, we will notify you by email.

EITHER mail the complete Grant Application (pages 1-5) and additional required items to
Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019 (DO NOT USE STAPLES)
or email legible scanned pages (in PDF format only) to ggf@glenngarcelonfoundtion.org. Note: photos must be in jpg format

*If you have any questions, contact us at 503-969-7651 or info@glenngarcelonfoundation.org*

Please be aware that funds are limited and based on availability and need.

**Before submitting application, please check to be sure you have completed/included the following:**

- Page 1
  - Personal information fully completed
  - Signature
- Page 2
  - Financial information fully completed
  - Signature
- Page 3
  - Proof of income for each employed person in household
  - Current bills requesting payment for
  - Medical reports (pathology and recent MRI)
  - Optional Items:
    - Personal story
    - Narrative written by friend or family member
    - Photos (optional) (high quality, preferably digital) ATTACH to email when sending
      - We are unable to return photos, so send those you have duplicates of
  - Signature
- Page 4
  - Medical information fully completed
  - Demographic Section completed
  - Signature
- Page 5
  - Signature at top of page
  - You may not complete any portion of this page. It must be completed by the doctor treating you for your brain tumor (neurosurgeon, oncologist, neurologist, or a designated person in their office).