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 (with the exception of December, when the review will be on the 15th), so your application must be received in its entirety prior to that date to be considered for that month.

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 info@glenngarcelonfoundation.org by calling 503-969-7651.

FAQs

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, but priority to go to applicants from the states in which we fundraise (currently Arizona, Colorado, Oregon and Texas). Applicants must reside in and be receiving treatment in the United States 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.
  o By scanning and sending to ggf@glenngarcelonfoundation.org
  o 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.

When will I hear if my grant has been accepted or denied?
• We will send you an email when we receive the packet.
• 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 given a grant, am I allowed to apply for additional help from the Glenn Garcelon Foundation?
• Due to the amount of applications we receive, an applicant can only apply for a grant once every two years (24 months)

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

Revised 11.01.19
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, Name of parent/guardian ________________________________

If patient is a minor, Email address of parent/guardian __________________________

If patient is a minor, Phone number of parent/guardian _________________________

Name of relative (not living with you) ______________________  Relationship _________

State where relative resides _____  Email and Phone number 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

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PATIENT NAME

FINANCIAL INFORMATION

Is patient currently employed? Yes No If employed, employer’s name ________________________________

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)

________________________________________________________________________________________________________________________________________________________

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
ADDITIONAL REQUIRED 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 items.

PROOF OF INCOME

- **First two pages** of signed copy of 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.**

PERSONAL STORY

- On a separate sheet of paper, please “tell your story,” so that we may get to know more about you and the journey you are on. We want to know about you: career, interests, family, what life was like both before and since your diagnosis, etc.

PHOTOS

- 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 potential 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 need 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.

BILLS

- 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

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

If I am awarded a grant, I 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

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MEDICAL INFORMATION
TO BE PROVIDED BY APPLICANT/PATIENT

Neurosurgeon’s or doctor’s name and phone number (REQUIRED)
________________________________________________________

Social Worker’s /Patient Advocate name and phone number (REQUIRED)
________________________________________________________

Oncologist’s name and phone number (if applicable)
________________________________________________________

Hospital where receiving treatment(s)
__________________________________________________________

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. Further, I give permission for my doctor(s) and staff to provide information about my medical condition and treatment to the Glenn Garcelon Foundation.

__________________________________________________________
Signature of applicant or guardian ____________________________

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE

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 to ggf@glenngarcelonfoundation.org. Your application will not be forwarded to the Review Committee until the entire packet is submitted. We will contact you via email if additional information is needed and you will be notified by email once your application has been evaluated. Please be aware that funds are limited and based on availability and need.

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

Revised 11.01.19
I give permission for my doctor(s) to provide information 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

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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.

ADD ggf@glenngarcelonfoundation.org to your contact list, so we can contact you if necessary.

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

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
  - Personal story
  - Photos (high quality, preferably digital)
    - We are unable to return photos, so send those you have duplicates of
  - Current bills requesting payment for
  - Medical reports (pathology and recent MRI)
  - Signature

- **Page 4**
  - Medical information fully 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).