Patient Care Fund
Grant Application

Amy Gallagher Foundation
A bright light for brain cancer

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grant application

Thank you for your interest in the Amy Gallagher Foundation's Patient Care Fund. The Fund seeks to provide financial aid for treatment to adult patients impacted by brain tumors.

About Us

The Amy Gallagher Foundation is a private nonprofit trust supported completely by volunteers. The organization is committed to creating public awareness, promoting research and education, and raising funds for patient care and hospital-based research, in order to find a cure for this life-threatening disease.

About the Grant

The Patient Care Fund is available to all eligible residents of Rhode Island and Massachusetts. Financial assistance is provided for deductibles and/or copayments directly related to care for adult primary brain tumors and can include pharmacy copayments and deductibles, inpatient or outpatient copays and deductibles necessary for medical treatment:

- Applicants must enclose a copy of their most recent tax return. If the Applicant is not required to file a tax return, enclose a letter from the IRS confirming such. The IRS can be reached at 1-800- 829-1040;
- Applicants must file for an Explanation of Benefit (EOB) with their insurance company and submit with this application; and
- Applicants must provide a written estimate for the cost of treatment or medication.
- Check(s) issued will be made payable to the patient if services have already incurred. Check(s) will be made payable to the provider if services have not yet been incurred.
- Each request for assistance requires the applicant to file a separate Grant Request and submit a copy of his or her most recent tax return.

Important Dates

Applications must be received no later than November 15, 2016. All applications will be reviewed by the Board of Advisors who will award approved applicants a check made out to them for services already incurred or to the provider if services have not yet been incurred. This applies to both medical and pharmacy expenses. Grant awards will be mailed to approved applicants before November 30, 2016.

Getting Started

Please complete the enclosed application and send in all required materials by email or postal mail.

Email address	info@amygallagherfoundation.org
Mailing address	Amy Gallagher Foundation Patient Care Fund PO Box 125 Jamestown, RI 02335

We're Here to Help

If you have any questions regarding the application, please send an email to info@amygallagherfoundation.org.

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Application

today's date _____

Patient Information

name _____ age _____

home address

street _____

city _____ state _____

email _____ phone _____

spouse's name _____ number of children _____ ages of children _____

Healthcare and Medical Background

date of diagnosis _____

health insurance company policy number _____

primary policy holder (family member responsible for coverage)_____

relationship to applicant _____

home address

street _____

city _____ state _____ zip code _____

email _____ phone _____

physician's name _____

medical group affiliated with (if applicable) _____

physician's address

street _____

city _____ state _____ zip code _____

email _____ phone _____

Financial Information

monthly gross patient income $_____ monthly gross income partner / spouse $_____

Patient and spouse monthly income (total combine gross amount) $_____ social security $_____

pension $_____ short term disability income $_____

long term disability income $_____ veterans benefits $_____

other income $_____

Additional Information

Have you sought financial assistance for the services requested above from any other sources? Yes/No

If yes, from whom? _____

When was the request made? _____

What was the result? _____

Are there any other relevant circumstances we should be made aware of? _____

Required Materials

Please provide the following information in a separate document:

- Please explain in detail the type of treatment you seek and the type and amount of funding you need. *This grant is not intended to duplicate coverage.*
- Please explain why you need the requested treatment.
- A professional letter of support from your doctor must be enclosed.
- Please explain in detail why health insurance alone is not a viable option towards acquiring the requested treatment.

FOR OFFICE USE ONLY

Service Requested _____

Service Approved Yes / No

Amount Approved _____

Authorized Signature _____ Date _____