Thompson-Mason Brain Cancer Foundation

Application for Assistance.

Transportation

Lodging

Household Bills

Meals

Living Expenses

Medical Bills

Co-Payments

Memorable Vacations

For assistance needed in completing the application, contact us at

606-207-0293
or
info@braincancerhelp.org

The main goal of the Thompson-Mason Brain Cancer Foundation is to help low income brain cancer patients and families with the cost of traveling to seek the best medical treatment possible. We would provide gas cards for fuel purchases, reserve and pay for hotel rooms and make sure that they do not go hungry. We want to help all brain cancer patients, with both malignant and benign tumors.

As the foundation grows we would like to provide the following if financially possible:

Aid low income patients in paying medical bills for services provided at cancer treatment facilities. We would request copies of the bills and make payments directly to the institution.

Provide financial assistance to care givers of patients that are in the final stages of their battle with cancer. We realize it would be a tremendous strain on some families to miss the income of the care giver when they are needed at home full time.

If the treatment being received and condition of the patient allows, we would like to finance a memorable family vacation. We would handle all aspects of planning the trip. The only thing that would need to be provided is where and when they want to go. We would make direct payments for the traveling and lodging expenses and provide pre paid credit cards for meals.

(We would eventually like to provide scholarships for children of brain cancer patients that have passed. Qualifications to meet the criteria will be decided if funding comes available.)

Please note that if we have have funds available and the applicant qualifies for aid, we will do our best to help in a timely manner as we know first hand that time is of the essence.

Instructions

To apply for benefits, follow these easy steps:

1. Complete the Application
Complete the **entire** application. If not, this will slow down the application process. Please be accurate. If you are applying for someone else, answer the questions as they relate to that person.

2. Submit the Application
Once you have completed the application please mail the original. Application processing begins based on the date it is received by Thompson-Mason Brain Cancer Foundation

3. Supporting Documentation
Check the Supporting Documentation list carefully to see what proof is required for the assistance you are applying for. Include copies of statements (originals only when requested)

Equal Opportunity
This application will be considered without regard to race, color, gender, age, disability, religion, national origin, or political belief

Questions?
If you need assistance with this application or have any questions, contact Thompson-Mason Brain Cancer Foundation by calling 1-606-207-0293 or email info@braincancerhelp.org

FAQS

Do I Have to Be a Citizen?

No. However, you must have proof of residence (an address), a valid work visa, Medicaid or Medicare in order to apply.

How Soon Will I Receive Assistance?
This depends on how soon you complete and return your application, however, once the application is received and depending upon the type of assistance requested, assistance can begin within 2 days up to 3 weeks. In case of emergency, please call us at 1-606-207-0293

Can I Complete the Application for Someone Else?
Yes. However you must complete the area for Authorized Representative along with your signature

Will you Pay Me Directly?
No. We make direct payments only to the vendors which have provided you services.

Will All of my Expenses be Paid?
No. We will consider expenses which you provide statements for (except transportation).

How Often Can I Apply for Assistance?
You may re-apply for assistance 6 months after the original date of your first application if you are either approved or denied.

Where Do I Send The Completed Application?
You can mail the completed application at the address below. **Please call or email after sending the application so we are aware that it is on the way and we can be looking for it to arrive.**

Thompson-Mason Brain Cancer Foundation
PO Box 1235
Morehead, KY 40351

DISCLAIMER

Please note the following regarding the application process:

1. Thompson-Mason Brain Cancer Foundation makes no guarantees of approval of an award due to the completion and submission of an application.

2.Thompson-Mason Brain Cancer Foundation requests supporting documentation to substantiate patient expense requests for assistance but does not guarantee that submission of any documentation constitute an agreement to payment of all submitted invoices/statements or services.

3.Thompson-Mason Brain Cancer Foundation has no set limit for patients and the amount paid will be decided by the board of directors on a case-by-case basis.

5.Thompson-Mason Brain Cancer Foundation processes applications on a case-by-case basis. Some of the factors considered in determining award amounts include monthly income, number of household members and overall expenses.

5. By signing a completed application you have agreed that you understand that the Thompson-Mason Brain Cancer Foundation program and its accompanying programs provide assistance for **low-income brain cancer** patients. Although decisions on awards are based on many factors, please consider the federal poverty chart as the guideline.

6. Due to current HIPPA laws, Thompson-Mason Brain Cancer Foundation is not always able to verify balances with a creditor. Since we are not the patient, many creditors will not speak with our staff regarding some of the simplest inquiries, such as outstanding balances. We may attempt to verify the balance electronically using information which you provided. If a statement or invoice is older than 20 days, we MUST verify the balance with the creditor only if they are willing to reveal such information. If we are unable to verify a current balance, we may then seek other expenses where we may be able to assist. If enough information is provided within the patient application, we proceed with processing those expenses. If not, we will make every attempt to contact the applicant.

7. Please note that you are within your right to close your application at any time prior to a final decision and not accept assistance.

8. Denial of an award is not taken lightly therefore guidelines that govern a denial are some of the following: a)fraudulent application; b)mis-representation of income; c)patients who are not in active treatment—**the application process must begin before treatment has ended**; d)denial can also occur at any time during the application process if it is discovered that an applicant, his/her authorized representative (including social workers, patient navigators or other health official) has conducted him/herself in an inappropriate manner or exhibited inappropriate behavior to any staff member or volunteer; and e)if after receiving a "supporting documentation letter" from Thompson-Mason Brain Cancer Foundation, the patient did not return all requested supporting documentation or failed to contact us within a reasonable amount of time.

Supporting Documentation

1. A Letter from Your Physician

The letter must be typed on original letterhead. No exceptions.

The letter must come from your physician, hospital or treatment facility and have the address and telephone number. It must be signed by your physician or oncologist.

The letter must state the current diagnosis, course of treatment and length of treatment.

2. Proof of Income

Income must be verified before the application can be processed.

Check stubs or bank statements showing deposits from the past three months. In some cases, income tax returns may be requested.

If you are receiving or have applied for Social Security, Disability, etc., a copy of the letter of application, award or denial must be included.

3. Traveling for Treatment.

If you are seeking assistance for the expense of traveling to receive treatment, provide the full name, address and phone number of the treating facility. Include the dates of travel.

If time is of the essence, we may request that the doctor at the treating facility either contact us for verification or permission is given for us to contact the doctor. If it is the latter, you will be responsible for contacting the doctor to give him/her permission to discuss the treatment with Thompson-Mason Brain Cancer Foundation. You would then provide us with the contact information and phone number.

4. Copies of Statements/Invoices for which you Seek Assistance.

Only submit copies of statements/invoices for which you are seeking assistance unless requested.

If you do not include copies of the statements/invoices your request will not be considered.

Do not submit originals unless requested.

Application for Assistance

First Name (Patient) ______ Middle Initial ______ Last Name ______ Maiden Name (if applicable) ______

Home Address ______ City ______ State ______ Zip ______

Mailing Address (if different from above) ______

Daytime Phone Number ______ Cell Number ______ Email Address ______

Gender: ______ Male______ ______ Female ______

How Did You Hear About Us?______

I am applying to receive the following assistance:

___Travel related expenses needed to seek treatment including help with:

Circle all that apply: Fuel Lodging Food Auto Rental Airfare

Other:______

___Medical Expenses:

Co-Payments Prescriptions Doctors Visit Outstanding Bills

Other:______

___Help with everyday bills when leave of absence is taken by primary care giver of patient that is in the final stages:

Electric Gas Water Telephone Groceries

Other:______

___Memorable Family Vacation: Please include a separate page detailing the destination, mode of transportation, departing city, and full legal names and ages of all persons traveling.

To make sure you receive all the help you qualify for, answer the following questions by circling yes or no and include additional information where requested. Empty spaces will delay the application process.

Are you currently employed? Yes No

If no, when was the last day/date you worked ______________________________

Do you currently have medical insurance? Yes No___

If so, please provide the name of the insurer:

____

Have you or anyone in your household:

Circle one: Applied for Is Receiving Been Denied

Circle One: Disability Social Security

Do any children in your home have a parent not living with them? Yes No

Are you or any children in your household (or which you provide support), currently attending grade school, high school, a college or university? Yes No

If so, what year of study are you/the student currently in______________________

How many people currently reside in your household? ______________

What is your current marital status? Married Divorced Single Separated Widowed

Personal/Authorized Representative: You may authorize someone else to apply for benefits for you or speak on your behalf. The authorize representative must include name, signature, phone, relation to applicant and their signature. Applicant must then sign to indicate approval.

____

____
Name of Authorized Representative

____
Signature of Authorized Representative

____
Relation to Applicant

____
Applicant Signature

____
Phone Number

NOTE: Your signature also indicates that if your authorized representative provides incorrect information that causes us to award benefits you are not entitled to receive, you may have to repay the benefits to Thompson-Mason Brain Cancer Foundation.

Please list each person who lives in your home **including yourself**. Include any unborn children and due date.

NAME (spouse, child, stepchild)	**RELATION**	**DATE OF BIRTH**	**SEX**
____ Applicant	____ Self	____	☐ M ☐ F
____	____	____	☐ M ☐ F
____	____	____	☐ M ☐ F
____	____	____	☐ M ☐ F
____	____	____	☐ M ☐ F
____	____	____	☐ M ☐ F

Household Income: List income received and/or expected for this month. For wages we will need stubs from the last 30 days. **If self-employed**, previous years federal income tax records.

Monthly Income (We require your **GROSS** income (income before deductions) and your **NET** income (the amount you take home).

____________________ **GROSS** income

____________________ **NET** income

Please provide copies of your letter showing that you have been awarded, applied for or denied any of the following:

Self-employment $____________________ Disability Payments$____________________

Unemployment Benefits $____________________ Social Security $____________________

I understand that . . .

Knowingly providing false information or withholding information may result in criminal, civil or administrative action (including denial of benefits or required repayment of benefits).

My signature (or the signature of my representative) authorizes Thompson Mason Brain Cancer Foundation to determine if I am eligible for benefits.

My signature below certifies that I am a citizen or legal resident of the U.S. or that I posses a valid work visa.

I,____________________, swear that the information given on this form is true and correct.

____________________ **Signature of Applicant/Authorized Representative**

____________________ **Date**