Glenn Garcelon Foundation

empowering & supporting brain tumor patients

Welcome to our Grant Application page.
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.

There are four (4) parts to the application process. Please be sure to read all the instructions carefully prior to completing the application. Our Review Committee is not able to look at an application until they have received it in its entirety.

Please add glenngarcelonfoundation@msn.com to your contact list. If we need to contact you, we want to ensure that our communication does not end up in your junk mail file.

Please let us know if you have any questions
by emailing glenngarcelonfoundation@msn.com or by calling 503-969-7651.

FAQs

Are grants only given to those residing in certain states?

- *No, we accept applications from any of the 50 states.*

What is the typical amount given to a qualified applicant?

- *Because we have so many applicants, the maximum amount we give is $1000 per approved applicant.*

How do I submit the grant application?

- *The completed application can be submitted in one of two ways.*
  - *By scanning and sending to glenngarcelonfoundation@msn.com*
  - *By mailing the packet to Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019*

When will I hear if my grant has been accepted or denied?

- *We will typically send you an email when we receive the packet.*
- *The Review Committee typically has a response to us within two weeks after they receive the packet in its entirety.*
- *You will be notified by email and/or 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)*

Applicant # (to be completed by Review Committee)

Application for Foundation Assistance

PERSONAL INFORMATION This page to be completed by patient or person requesting assistance

PLEASE PRINT ALL INFORMATION CLEARLY

Full name of person to receive grant ____Gender: M F

Date of birth____/____/______ Age ______ Phone number(s) ____

Address ____

City, State, Zip Code ____

Email address(es) ____

Spouse's name ______________________________ Spouse's phone number _________________________________

Hospital where receiving treatment(s) ____

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)** ____

Amount being requested: ___________________________________

Type of help requested: ____

Submit copies of any bills that you are requesting to be paid

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)

If patient is a minor, name and phone number of parent/guardian ____

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 the patient is not a minor, and you are a spouse, family member or caregiver, 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.

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

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 PATIENT NAME____

HEALTH INSURANCE INFORMATION

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 ____

Monthly premium? _____________ Are prescription drugs covered? Yes No

HOUSEHOLD FINANCIAL INFORMATION

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

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

Monthly rent/mortgage ___________________ Approximate monthly utility bill? _________

Number of people in household? _________ Ages? _____________________________________

Number of employed people in household?_________If patient is a minor, is parent/guardian currently employed? Yes No

If there are unemployed adults in house, other than patient, why are they unemployed? _________________________________

____

Family Income Sources (circle all that apply)

Social Security Salary Pension Unemployment Short-term disability

SSD Disability SSI Public assistance Family/Friends Other (please specify) ____________________

PROOF OF INCOME: the following need to be submitted with this application (if patient is a minor, financial records of parent/guardian need to be submitted). **All income earners in household need to submit these items**.

First two pages of **signed copy of income tax return for the past 2 years** (you may 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.

Total Annual Family Income _______________

Application will not be processed if this information is not provided

If I am a grant recipient, I agree to inform the Glenn Garcelon Foundation in writing of how the grant is used, and to allow that information, a brief history of my brain tumor journey, and picture to be used on their website, at fundraising events, and as needed to further the mission of the Foundation. I also 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

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

PERSONAL STORY

1. 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.
2. **Enclose several high quality pictures** High quality photos are imperative, as they will be used on our website, and perhaps at our fundraising events, in promotional materials and/or in meetings with potential sponsors. Scanned pictures will not be high quality enough. *Please do not fold, staple or tape the pictures*. You may send them digitally in jpg format to glenngarcelonfoundation@msn.com. Put your name in the subject line.

GRANT DISTRIBUTION INFORMATION

If you are awarded a grant that will be used to pay bills (rent, mortgage, utilities, medical bills, etc.) we will need copies of the bills that include the account number and mailing address. Please list the names of the companies you are providing bills for below

PLEASE PRINT ALL INFORMATION TO AVOID DELAYS

Name Individual/Company/Agency check should be "Paid to the Order of"? (use a separate sheet, if necessary for additional payees)

____

____

____

Is there anything else we should be aware of in regard to where a possible grant is to be sent?

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE

I certify that the information in this application 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 date

How did you learn about the Glenn Garcelon Foundation?

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

Mail the complete Grant Application (pages 1-4) to Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019 or email legible scanned pages to www.glenngarcelonfoundation@msn.com. Your application will not be forwarded to the review committee until the entire packet is submitted. We will contact you if additional information is needed and you will be notified by mail once your application has been evaluated.

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

glenngarcelonfoundation@msn.com glenngarcelonfoundation.org

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

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 I have not completed ANY part of this page other than my signature below.

____

Patient signature

MEDICAL INFORMATION **This section can ONLY be completed by your oncology nurse, doctor, social worker or other health care professional**

Patient Name ____

Date of Diagnosis: ________ Type of brain tumor: __________________________________ 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 in the past twelve months (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 will need in the future (circle all that apply)

Chemotherapy Radiation MRI Surgery Palliative care

Bone marrow/stem cell transplant Other (specify) ____

From your perspective, is patient able to work? Yes No ____

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 ____________________

PLEASE ATTACH PREPRINTED LETTERHEAD OR ENVELOPE ASSOCIATED WITH THE CLINIC/HOSPITAL COMPLETING THIS PAGE. IT WOULD BE APPRECIATED IF YOU COULD WRITE A SHORT STATEMENT ON THE PATIENT'S MEDICAL CONDITION AND YOUR FINANCIAL NEEDS ASSESSMENT OF THIS PATIENT.

If you wish to talk with us, please call (503-969-7651) or email (glenngarcelonfoundation@msn.com) us.

____ ________________________

Signature of Medical Professional Date

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 entirely.

Please be sure all parts have been completed as requested and signed.

If you have any questions, contact us at glenngarcelonfoundation@msn.com or 503-969-7651 CST.

ADD glenngarcelonfoundation@msn.com to your contact list, so we can contact you if necessary.

- Page 1
  - Personal Information completed
  - Signature verifying validity of information
- Page 2
  - Health Insurance Information completed
  - Proof of income attached for each employed person in household
  - Signature authorizing us to use your picture and story and verifying validity of information
- Page 3
  - Your story
  - Photos **(high quality, preferably digital)**) Please do not fold, staple, tape. It would be preferable to have the photos scanned and saved in jpg format, and emailed to glenngarcelonfoundation@msn.com
  - Payment processing information complete, if applicable
    - Copies of bills that you are requesting to be paid. Be sure bill includes mailing address of vendor and the account number
  - Signature verifying validity of information and giving authorization to your doctor(s) and staff to provide us with information
- Page 4
  - Signature authorizing medical personnel to release your medical information and other information
  - Medical Information completed and signed by medical professional involved in your care. You MAY NOT complete any part of this
    - A letter from your doctor, social worker or patient advocate would help the Review Committee make an informed decision
  - Letterhead or envelope from medical facility associated with above medical professional
- Add glenngarcelonfoundation@msn.com to your contact list

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