



**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](mailto: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](mailto: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](mailto: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 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 donation \_\_\_\_\_ 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

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

**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 \_\_\_\_\_

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 briefly “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 may be used on our website, 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](mailto: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 the following information in order to process the payment. In addition, we will need copies of bills.

**PLEASE PRINT ALL INFORMATION TO AVOID DELAYS**

Name and Address of Individual/Company/ Agency check should be “Paid to the Order of”? (use a separate sheet, if necessary)

\_\_\_\_\_

\_\_\_\_\_

Contact Person \_\_\_\_\_ Phone number \_\_\_\_\_

Account # \_\_\_\_\_ Email address (if available) \_\_\_\_\_

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

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How did you learn about the Glenn Garcelon Foundation?

- |                                     |                                       |                                       |   |
|-------------------------------------|---------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> friend     | <input type="checkbox"/> website      | <input type="checkbox"/> news article | <input type="checkbox"/> doctor/social worker |
| <input type="checkbox"/> web search | <input type="checkbox"/> social media | <input type="checkbox"/> event        | <input type="checkbox"/> 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](mailto: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](mailto:glenngarcelonfoundation@msn.com)      [glenngarcelonfoundation.org](http://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.

\_\_\_\_\_  
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 \_\_\_\_\_

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) \_\_\_\_\_

**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](mailto: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 entirety.

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

If you have any questions, contact us at [glenngarcelonfoundation@msn.com](mailto:glenngarcelonfoundation@msn.com) or 503-969-7651 CST.

**ADD [glenngarcelonfoundation@msn.com](mailto:glenngarcelonfoundation@msn.com) to your contact list, so we can contact you.**

- 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](mailto:glenngarcelonfoundation@msn.com)
  - Payment processing information complete, if applicable
    - Copies of bills that you are requesting to be paid
  - 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
    - 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](mailto:glenngarcelonfoundation@msn.com) to your contact list