**MBB ALS Grant Request**

**PATIENT INFORMATION**: (please print clearly)

First Name: ________________________________________ Last Name: __________________________________________

Date of Birth: ___________________________ Age: __________ Male Female (circle one)

Marital Status: Single Married Separated Divorced Widowed (circle one)

Street Address: ____________________________________________________________________________________________

City/Town: _______________________________________ State: ______________ Zip: _________________________________

Phone Numbers: Home (______)_______________________________________
Work (______)_______________________________________
Cell (______)_______________________________________

Email Address: _______________________________________________________

If patient is a minor (under 18), name of parent or guardian: _______________________________________________________

How did you hear about the Mary Beth Benison Foundation? _______________________________________________________

Briefly explain your circumstances/case, including diagnosis and financial need: (Note: We require medical certification from treating physician. Please have your physician fill out the page of this document entitled Physician's Certification Letter. If you are working with a social worker have the Health Care Professional page completed.

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Mary Beth Benison Foundation * P.O. Box 160, Holden, MA 01520 * 774-275-0240
Email: mbbfoundation@gmail.com * www.mbbloves.org

**PURPOSE:**
My request is for assistance with the following expenses:

_______ **Electric** Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

_______ **Telephone** Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

_______ **Heat (Gas/Oil)** Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

_______ **Rent/Mortgage** Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

_______ **Medical Bill or Home Health Services not covered by insurance** Amount Requested: _______________

Check made payable to: ____________________________________________ Account #________________

Describe Type of Care: __________________________________________

_______ **Medication or Medical Equipment/Supplies not covered by** Amount Requested: _______________

Check made payable to: ____________________________________________

Type of Equipment/Supplies ____________________________

_______ **Other** Amount Requested: _______________

Check made payable to: ____________________________________________ Account # ____________________________

Explanation: _____________________________________________________________________________________________

Special Instructions: _______________________________________________________________________________________

**_________ I have attached copies of the bills I would like the Mary Beth Benison Foundation Inc. to consider for assistance**

****Please attach a copy of the bill(s) or invoice for which payment is requested.** The copy must include: the name on the account, account number, a current due date, amount due, and remit to address.**



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**Physician Certification Statement:**

Patient Name: ______________________________________________

Date of Birth: ______________________________________________

Address: ______________________________________________

City/State/Zip Code: ______________________________________________

Phone Number: ______________________________________________

Patient's Diagnosis: ______________________________________________

Date of Diagnosis: ______________________________________________

Is patient in active treatment? ______________________________________________

Please list any additional information: ______________________________________________

______________________________________________

Physician Name: ______________________________________________

Hospital/Medical Facility Name: ______________________________________________

Address: ______________________________________________

City/State/Zip Code: ______________________________________________

Phone Number: ______________________________________________

Fax Number: ______________________________________________

Physician NPI:______________________________________________

**I certify that the above listed information is accurate and current.**

Physician's Signature:______________________________

Date: ______________________________



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**Social Worker/Health Care Professional Information:**

Name: ______________________________________________

Hospital/Clinic/Organization Name: ______________________________________

Address: ______________________________________________

City/State/Zip Code: ______________________________________________

Phone: ________________________ Fax: ________________________

Email: ______________________________________

Referring Professional Signature: ________________________ Date: ____________

Information regarding the qualifying amount for this patient will be sent to you via email.

**Medical Information Release:**

I, ______________________ hereby release ______________________ and members of

(patient name) (physician name)

his or her staff to communicate via letter or phone with the Mary Beth Benison Foundation Inc. and its representatives for the purposes of confirming that I am a patient being treated for ______________________.

(diagnosis)

**X**______________________________________________

(signature) (or signature of parent or guardian if minor, under 18) (date)

## Permission to Share Your Story on our Website and Social Media pages:

The Mary Beth Benison Foundation Inc. is a 501(c)3 non-profit organization. We like to keep our supporters up to date with what the foundation is doing and how we are helping people. From time to time, we share on our social media pages and website stories of the patients and families who we have helped.

**Please check one below:**

◯ **I grant MBB Foundation permission to share my story on the foundation's social media pages and website. (If you select this we will share your name, city, State where you live and the reason you contacted the foundation looking for assistance and how we helped)**

◯ **I grant MBB Foundation permission to share part of my story on the foundation's social media pages and website. (If you select this, we will only use your first name and share a little of your story and how we helped)**



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