



MBB 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.)



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 not covered by insurance** Amount Requested: _____

Check made payable to: _____ Account # _____

Describe Type of Care: _____

_____ **Medical Equipment/Supplies/Home Health Services** 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 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.**



Cont.

HOUSEHOLD FINANCIAL INFORMATION:

Number of people in household: _____

Please list all of the people in your household.

Name	Date of Birth	Relationship to Patient	Employer/Employment Full Time/Part Time Self- Employed Unemployed/Disabled Child/Student	Income Per Year
		Patient		

TOTAL ANNUAL FAMILY INCOME: \$

INCOME VERIFICATION:

FAMILY INCOME SOURCES (please check all that apply):

Social Security (retirement)
 Salary
 Pension
 Unemployment
 Child Support/Alimony

Public Assistance
 Short Term Disability
 SSD (Disability)
 SSI

Family/Friends provide support
 Other – specify _____

_____ I have attached copies of my income sources (most recent award letter, benefit statement, checks or pay stubs).

Have you applied to other agencies for assistance? No Yes Which ones? _____

We strongly encourage you to seek assistance from any and all resources. Assistance from other agencies does not affect eligibility with MBBF.

I declare that the information on this application is true and correct to the best of my knowledge:

PATIENT SIGNATURE:

X _____ DATE: _____

Please print full name: _____

If Patient is a minor (under 18 years old), parent signature:

X _____ DATE: _____

Please print full name: _____



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: _____



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 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. Whenever we help someone we usually share a post on our social media pages and website about the patients and families and how we have helped.

Please check one below to grant the foundation permission to share your story or at least part of it:

- 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, we will share your story and the reason you contacted the foundation 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)