The Pam Stewart Cancer Foundation's Grant Application

Contact Information:

Patient Name:_____

Date of Birth: _____/_____/_____

Address:_____

_____

Phone:_____ (Cell, Home)

Email Address:_____

Spouse/Partner Name (if applicable):_____

Personal Information:

Diagnosis (Type of Brain Tumor): _____
Date of Diagnosis:_____
Treating
Hospital:_____
Treating Doctors:_____
Do you have any dependents? ____Yes _____No
If yes, please list name, age, and relationship:
_____
_____
_____

Employment Status – Patient (Parent or Legal Guardian if applicable)

Employed: _____Yes _____No
Employer:_____
Phone Number ( )_____
Address_____
Date of hire_____ Hours worked per week_____
Unemployed _____Yes _____N/A If unemployed, last date worked_____
_____Self-Employed _____Retired _____Disabled
Annual Gross Income_____

Employment Status – Spouse/Partner

Employed _____Yes _____No Unemployed ___Yes __N/A If unemployed, last date worked:_____
_____Self-Employed _____Retired _____Disabled
Employer's Name_____
Phone Number ( )_____
Address_____
Date of hire_____ Hours worked per week_____ Annual Gross Income_____

Please provide a short explanation detailing your request for assistance. Where applicable, be sure to include the type of assistance requested (travel expenses for treatment, assistive device(s), co-pays, etc.) and the amount needed.

_____
_____
_____
_____
_____
_____
_____
_____

To Protect Its Interests, The Pam Stewart Cancer Foundation May Request any of the following:

- Letter from treating physician verifying applicant diagnosis **(Required).**
- Copy of Pathology Report verifying diagnosis.
- Interview with applicant or family member and Pam Stewart Cancer Foundation Board Member(s)
- Copy of Applicant household federal tax return for the most recent year.
- Applicant household bank statements from the last three months including checking, savings, and CDs.
- Copy of Applicant driver's license or State ID.

This is a one-time grant eligible to patients with a primary malignant brain tumor. The PSCF reserves the right to determine if I meet the criteria based on a review of the application and other supportive information and is not required to provide a reason for denied applications.

I hereby authorize the release of information necessary for this application to The Pam Stewart Cancer Foundation, Inc. ("PSCF"), so that my request for assistance may be processed. I certify the information I have stated here is true and accurate and I am eligible for this Grant. I also understand that PSCF may verify the information on this application and that deliberate misrepresentation of information may subject me to denial of assistance. I give permission to PSCF to discuss this application with any others deemed necessary to verify my information and/or identify additional sources of assistance. I understand that all information will remain as private as possible within these entities.

Patient Signature:_____

Printed Name:_____ Date:_____

Parent/Guardian *(If applicable*):_____

Printed Name:_____ Date:_____