INFORMATION FORM

Patient Name _____ **Date:** _____

If Patient is a minor, Parent Applicant Name _____

Eligibility Criteria

1. Must a San Diego County Resident.
2. Any person who has been diagnosed with a primary brain tumor and is in any phase of treatment or recovery.
3. Patient must have financial difficulty (determined by the SDBTF Board), limited liquid assets, and be otherwise unable to cover the cost of the intended use of the grant.
4. Patient must complete the San Diego Brain Tumor Foundation (SDBTF) Grant application in full and provide all the items listed below.

Guidelines

1. This grant is provided to pay for expenses including but not limited to: chemo therapy treatments, medical bills, short-term financial support for housing, second opinion medical support, and assistance in defraying prescription costs.
2. With the application, applicants must also submit:
   a. A letter from their doctor stating they are treating the patient for a brain tumor
   b. A copy of pay stubs from the last 3 months for the patient/spouse/parent.
   c. A copy of the most recent pathology report or MRI
   d. A brief story about your diagnosis and your fight, along with a picture (if consent has been given below) – please email or mail the picture, faxed pictures are not clear.
   e. Copy of driver's license or Legal I.D.
3. Grant recipients are chosen by the San Diego Brain Tumor Foundation Board of Directors and Staff
4. Funding is awarded to eligible individuals on a first come, first served basis to the extent that funding is available.
5. Applications will not be reviewed until SDBTF has received all of the items listed previously in number 2. The review process will take 7-10 days.
6. Please return completed application to SDBTF.
   FAX: 619.923.0202
   EMAIL: info@sdbtf.org
   MAIL: SDBTF 852 5th Ave. San Diego, CA 92101

Once a Grant is awarded, the applicant will be notified. The applicant will then submit his/her expenses to the SDBTF, who pays each invoice directly to the vendor/doctor, up to the approved amount. *Please note we are not able to provide reimbursements to an individual (the patient) for previously paid bills.*

PATIENT'S INFORMATION

LAST NAME:	FIRST NAME:	DATE OF BIRTH:
Gender: Male or Female		
HOME ADDRESS:	APT. #:	HOME PHONE #:
CITY/STATE:	ZIP:	WORK PHONE #:
EMAIL:		CELL PHONE #:
REFERRED BY:		
CHILDREN/SIBLINGS: (*please list names and ages)*		
MARITAL STATUS (circle one): Single / Married / Divorced / Separated / Widowed		
Country of Citizenship:	Race/Ethnicity:	
Legal to work in the United States?		
Spouse's Name: *(If Applicable)*		
How many persons are living in your household? **(include yourself, all adults and children)**		
Caregiver Name:	Phone Number:	
Emergency Contact:	Phone Number:	
Closest Relative:	Phone Number:	

PATIENT or CAREGIVER'S EMPLOYMENT

Are you Currently Employed? ❑ No ❑ Yes ❑ Full Time ❑ Part Time

Monthly Income:

If yes…
Employer Name: _____

Supervisor Name: _____ Contact Number: ( ) _____

If no…
When did you stop working? Month/year _____ / _____

Any other sources of income?

Total after tax household income per year
(Including all persons living in household**)**

PATIENT'S INSURANCE INFORMATION

Do you have health insurance? ❑ No ❑ Yes

Insurance Provider:	Policy Holder's Name:
Level of detuctible:	Type of insurance:

Are you currently collecting Social Security? ❑ No ❑ Yes

Are you currently collecting state disability? ❑ No ❑ Yes

Are you collecting long term disability? ❑ No ❑ Yes

Are you on MediCal/Medicare? ❑ No ❑ Yes	CCS? ❑ No ❑ Yes

PATIENT'S MEDICAL INFORMATION

DIAGNOSIS/TYPE OF TUMOR:		DATE OF DIAGNOSIS:
PHYSICIAN(S)		
PRIMARY CARE:	FACILITY:	PHONE:
NEUROSURGEON:	FACILITY:	PHONE:
ONOCOLOGIST:	FACILITY	PHONE:
NEUROLOGIST:	FACILITY:	PHONE:
SOCIAL WORKER:	FACILITY:	PHONE:

CAREGIVER'S INFORMATION

NAME OF PRIMARY CAREGIVER: (If patient is under 18, please list name(s) of legal guardian)		
RELATIONSHIP TO PERSON WITH BRAIN TUMOR:		
HOME ADDRESS:	APT. #:	HOME PHONE #:
CITY/STATE:	ZIP:	WORK PHONE#:
EMAIL:	CELL PHONE:	

PATIENT'S NEEDS

SERVICES PROVIDED BY THE SDBTF *(Please check areas of interest)*	***MAIN AREAS OF CONCERN*** *(Please check all that apply)*	
☐ **Financial Assistance** ☐ **Gas Cards** ☐ **Transportation** ☐ **Grocery Gift Cards** ☐ **Meal Services** ☐ **Support Group** ☐ **Respite**	☐ **Education** ☐ **Employment** ☐ **Financial** ☐ **Legal** ☐ **Housing**	☐ **Insurance** ☐ **Medical** ☐ **Medications** ☐ **Social**
	Other: _____	

I WOULD LIKE TO BE CONTACTED BY: ☐ Phone ☐ Email ☐ Mail ☐ In-Person

If you are requesting RENT/MORTGAGE/HOUSING assistance, please fill out the information below.

Name of Landlord/Bank:	Email of landlord:
Phone:	Check payable to:
Address:	How long have you lived at the above address?:

Financial Information		
LIQUID ASSETS	Current Value in ($)	NOTES
Cash on Hand		
Checking Account		Name of bank:
Money Markets: CD accts		
Savings Account		Name of bank:
Total		
FIXED ASSETS	Current Value in ($)	NOTES
Value of Principal Residence		
Equity in Principal Residence		
Automobile(s) Personal Property		
Other Fixed Assets		
Net Total		
Income	Current Value in ($)	
Income from place of employment		
Federal Social Security/Disability		
State Disability		
Child Support		
Spousal Support		
Cal Works		
Cal Fresh		
Financial Aid from other Non-Profits		
Total		
LIABILITIES	**Monthly Payments ($)**	NOTES
Student Loans		
Child Care / School Tuition		
Rent/Mortgage Monthly Payments		
HOA Fees		
Utilities: Electric, water, cable, house phone		
Cell Phone		
Renter's & Home Owner's Insurance		
Health Insurance		
Transportation/ Auto Loan & Lease Payments		
In Home Care		
Home Equity Loan		Loan Servicer:
Real Estate Taxes Due		
Income Taxes Due		
Credit Card Debt		
Medications/Medical Expenses		
Personal Lines of Credit		
Food		
Total		

Additional Notes:

Witness' Name (Please Print):

Witness Signature
X _____

Date / /

Medical Release of Information Authorization

I understand and grant my permission to all my doctors, social workers, clinics and hospitals to release all healthcare and billing information relating to my treatment and care for brain tumor and other related health problems to the San Diego Brain Tumor Foundation (SDBTF). I also grant my permission to discuss the above information with any designate representative of SDBTF by phone.

SDBTF agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their express permission. I specifically authorize the release of all my healthcare and billing information in your organization's possession. The purpose of my request is to assist SDBTF in determining my eligibility for financial assistance. This Medical Release of Information Authorization shall expire twelve months from its execution if not revoked prior thereto. SDBTF will not disseminate or release these medical records to any outside source without first obtaining prior express consent. I understand and agree that fulfillment of assistance may result in publicity whether or not SDBTF actively takes steps to publicize its service. I understand and recognize that the granting of any service and the participation of any person in the assistance is contingent upon approval by SDBTF. I also understand that there is a limit to the number of services that I will receive, depending on the type and cost of service being requested and offered. I understand and agree that no promises or assurances whatsoever have been made to me by any representatives of SDBTF regarding the assistance I am requesting.

I have read and understand the San Diego Brain Tumor Foundation Eligibility Information and Guidelines and I declare that the information furnished on this application form is true and correct to the best of my knowledge. I understand that all applications will be reviewed on a case-by-case basis and final determination will be made based upon other applications submitted and the availability of funds. I further understand that the San Diego Brain Tumor Foundation reserves the right to deviate from the Eligibility and Guidelines when special needs arise.

I hereby give my permission that this application and all the information provided be sent to the San Diego Brain Tumor Foundation. All information is reviewed by members of the SDBTF Board of Directors and Staff.

Patient's Name (please print):

Patient/Guardian signature
X_____

Date / /

PUBLICITY NOTICE-RELEASE

The San Diego Brain Tumor Foundation (SDBTF) holds events and fundraisers throughout the year to raise money to fund the primary objective of the foundation, supporting the needs of patients and families. People continue to support us because they want to see their money find its way to the people who need it most. We need your help to put a face and a name to that reality. To this end we will use your photo, your name, and your submitted story. If your application is approved, SDBTF may also use a brief description of how the assistance that you received has helped you. This will facilitate communication with our donors and help in attracting more contributors. This also can play a role in the application process, as the board has no way of knowing you, by submitting a short bio about you and your story, the board is able to get to know you better and understand your needs. Please acknowledge this notice-release by signing below.

I hereby acknowledge that SDBTF may use my name, photo background and story in PR, website and marketing materials which will include, but not be limited to, its newsletters website, mailings and general information brochures.

Patient/Guardian Signature _____ Date: _____

For Office Use Only			
Date Application was received:	Initials of Staff who received application:	Date Application was reviewed:	Initials of Staff who processed application: