GRANT GUIDELINES

The number of grants and amount awarded per calendar year will be determined based on the needs of the applicant, available funds are at the sole discretion of the Board of Directors of Brian's Foundation of Hope. All submissions are subject to review by the Board of Directors. BFOH's board reserves the right to make final determination to deny or approve award of a grant at their sole discretion. The Board reserves the right to request additional information as needed, and has the right to amend this application as needed without notice.

CRITERIA

Potential grant recipients must meet the following criteria to become beneficiaries of Brian's Foundation of Hope grant:

1. The recipient is planning to receive treatment, currently receiving or has recently received treatment for brain cancer.
2. The recipient agrees to submit proof for items that will be purchased with grant funds (see Grant Budget Form), as well as paid receipts for items purchased with grant funds.
3. The recipient must be a young individual living in or receiving treatment in the tristate area (NY, NJ, CT)

REQUEST CRITERIA may be made for, but not limited to:

1. Beyond Basic Needs (e.g., premade meal programs, private pay aides, hotel, travel accommodation, mortgage payments etc.)
2. Household chores (e.g., mowing, plowing, cleaning, etc.)
3. Other needs (please explain on a separate sheet of paper and attach to this application)

GRANT SUBMISSION

BFoH Grants may be submitted for review to the foundation by mail or e-mail to the following:

PO BOX 194 H
Scarsdale, NY 10583
briansfoundationofhope@yahoo.com
914-738-HOPE

APPLICATION

Please fill out the application to the best of your ability. Please provide medical documentation such as a pathology report along with your application. All medical documentation will be returned once grant eligibility has been determined.

APPLICANT INFORMATION

Name: ____ Phone:_____________________________

Address: ___________________________________ City: ___________________ State: _____ Zip:_______

County of residence: ___________________________ E-mail:_______________________________________

Date of birth: __________________

Marital status: Married Widowed Single Partnered Divorced Separated

PERSONAL STORY: Please share your story with us including how you were diagnosed, treatment, and how your life has changed since your diagnosis. Please include how this grant will help you live and celebrate your life with H.O.P.E.

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DESCRIBE YOUR NEED: What type of assistance do you request and how will this offer you H.O.P.E. and help you and/or your family live and celebrate your life?

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

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I understand and grant permission to all my physicians, social workers, clinics and/or hospitals to release necessary healthcare records and information relating to my treatment and care of a cancerous brain tumor to Brian's Foundation of Hope.

Brian's Foundation of Hope agrees that all medical information will remain confidential and any reports written about the program will not use any participants' names without their permission. I understand that this authorization will automatically expire one year from the date of my signature and that I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above.

Name: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

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Patient/Guardian
Signature: ______________________ Date Signed: ______________________

**Please remember to keep copies of all receipts submitted to foundation for review.

APPLICATION PERMISSION
Sign and date below that the information on this application is accurate and true:

Signature: ______________________________________ Date: ______________

Signature of parent and/or guardian (if under age 18 or if applicant is not deemed competent):
______________________________________ Date: ______________

PUBLICITY RELEASE

A part of the mission of BFoH is to raise awareness about brain cancer. Sharing your story and how you, and your family live your life will attribute to the success of our mission. We host and sponsor events to raise awareness and funding for patients. To make this possible, your personal information may be used on our website and publications.

By initialing and signing below, you are providing permission for BFoH to use the following information:

_______ Name *(First name only)*

_______ Photograph *(please include a photo of yourself or family with your application)*

_______ Personal story

Signature: ____ Date: __________________

Signature of parent and/or guardian *(if under age 18 or if applicant is not deemed competent):*

____ Date:__________________

_______ Please do not use my personal information

PRIVACY STATEMENT

Brian's Foundation of Hope protects the privacy of our applicants. Applicants' medical history will be kept confidential and secure. It will be reviewed by the Foundation's board members. BFoH may find it necessary to contact the references listed below determining eligibility.

Patient's Signature : ____ Date: __________________

Signature of parent and/or guardian (if under age 18 or if applicant is not deemed competent):____ Date: __________________

FOR PHYSICIAN ONLY

Physician's Name: ____ Phone: _______________________

Medical Facility: ____

Date of Diagnosis: ______________________ Diagnosis: ____

Currently in treatment: Yes No Date of most recent treatment: ______________________________

Type of treatment: (circle all that apply)

Surgery Radiation Chemotherapy Clinical trial Other: ___________________________

Physician's signature: ____ Date: ______________________

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REFERRING SOCIAL WORKER (if applicable)

Name: ____ Phone: __________________________________

Medical Facility: ______________________________________ E-mail: ________________________________

Signature: ____ Date: ______________________________