



Welcome to our Grant Application.

The Mission of the Glenn Garcelon Foundation is to empower and support brain tumor patients and their families. Our Grant Program is a vital way for us to fulfill our mission.

IMPORTANT INFORMATION: We only provide assistance to those with a PRIMARY brain tumor; if you have cancer elsewhere in your body that has metastasized to the brain, it is called a secondary brain tumor and we are unable to provide assistance.

In addition to the application, there are other required items that need to be submitted. Applications are reviewed towards the end of each month, so **your application must be received in its entirety no later than the 20th to be considered for that month** (with the exception of December, when the deadline to receive everything is the 13th).

Please add ggf@glenngarcelonfoundation.org AND sarah@glenngarcelonfoundation.org to your contact list. We will send an email when your application is received and let you know if we need any additional items. By adding our email address to your contact list, you will ensure that our communication does not end up in your junk mail file and keep your application from moving forward in the review process. Please let us know if you have any questions by emailing ggf@glenngarcelonfoundation.org by calling 503-969-7651.

FAQs

Can the application be completed in another language?

Unfortunately, we do not have any translators in our office so the entire application and all other required items must be completed in English.

Do you provide grants to patients with secondary brain tumors?

Due to the large amount of applications we receive, we only provide assistance to those with primary brain tumors.

Are grants only given to those residing in certain states?

No, we accept applications from any of the 50 states and the US territories. Applicants must reside in and be receiving treatment in the United States or its territories to be eligible.

What is the amount given to a qualified applicant?

Grants are based on need, the amount of applications received that month and the amount of funding available.

How do I submit the grant application?

The completed application may be submitted in one of two ways.

By scanning and sending (as PDF) to ggf@glenngarcelonfoundation.org **Screenshots are not accepted**

By mailing the packet to Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019 (no staples)

When are applications reviewed?

Applications go to the Review Committee on the 25th of each month, with the exception of December when they are reviewed on the 15th. **Your packet must be received in its entirety no later than the 20th (13th in December).**

When will I hear if my grant has been accepted or denied?

We will usually send you an email when we receive the packet. The Review Committee has a response to us within one week after they receive the packet in its entirety. You will be notified by email and mail of the decision of the Review Committee.

If I am awarded a grant, am I allowed to apply for additional help from the Glenn Garcelon Foundation?

Due to the amount of applications we receive, an applicant can only apply for a grant once every two years (24 months).



Financial Assistance Application

PERSONAL INFORMATION

PLEASE PRINT ALL INFORMATION CLEARLY

FULL LEGAL name of patient _____ Preferred First Name _____

Date of birth / / Age _____ Gender: M F other Patient Phone number(s) _____

Primary language spoken _____ Do you or someone in the home speak English? _____

Mailing Address _____

Street Address (if different) _____

City, State, Zip Code _____

Email address of **patient** _____

Spouse/significant other's name _____

Spouse/SO phone number _____ Spouse/SO email _____

If patient is a minor, names of parents/guardian _____

If patient is a minor, email addresses AND phone numbers of parents/guardian _____

Name of relative (not living with you) _____ Relationship _____

Email **and** Phone number of relative _____

Address of relative _____

Does the patient have health insurance? Yes No If applicable, annual deductible amount _____

If you have health insurance, please indicate type of insurance (circle all that apply):

Private Medicaid Medicare Medicare+ Medigap VA program Other (specify) _____

If private insurance, company name _____

I certify that the information contained on this page is true and accurate.

Printed name of person completing application

Signature of person completing application

Relationship to Patient? Self Spouse Family Member/Caregiver Health Care Professional

If someone other than the patient, parent, spouse or health care provider completes this application, we will need a notarized Power of Attorney specific to the state you reside in, in order for us to discuss this patient and the grant application with you.

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE

FINANCIAL INFORMATION

Is **patient** currently employed? Yes No If employed, employer's name _____

Spouse's or significant other's employer _____

If patient is a minor, parent/guardian employer's name _____

Number of people in household _____ Ages _____ Number of employed people in household _____

If there are unemployed adults in the home, other than patients, why are they unemployed? _____

INCOME

Total Annual Income **for all living in the household** _____

Checking Account Balance _____ Savings Account Balance _____ Bank Name _____

Family Income Sources (check/circle all that apply)

Salary Pension Social Security Unemployment Short-Term Disability SSD Disability

SSI Public Assistance Family/Friends Other (specify) _____

List the names of all other organizations and foundations that you have applied to for financial assistance. If you received assistance, please note next to the organization's name, how much you received and when. If a GoFundMe page or other fundraiser has been held to assist you, please include that information. (use a separate sheet, if necessary)

EXPENSES

Monthly Rent/Mortgage _____ Monthly Utility Bill _____ Monthly Phone/Cable/Internet _____

Number of Vehicles in Household? _____ Automobile Monthly Payment(s) _____

Monthly Insurance (auto, homeowners, life) _____ Credit Card balance _____

Medical Bills(s) Balance _____ Loan(s) Type & Balance _____

Other (be specific) _____

I certify that the information contained on this page is true and accurate.

Signature of applicant or guardian

date

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE

ADDITIONAL REQUIRED ITEMS TO BE SUBMITTED WITH APPLICATION

Your application cannot be forwarded to the Review Committee until we receive the completed application, as well as the following items.

REQUIRED ITEMS**PROOF OF INCOME** (in PDF format)

- **First two pages** of signed copy of **1040 income tax return for the past 2 years** (blacken out social security numbers) OR, if you do not file tax returns: please submit 3 months' worth of copies of pay checks/stubs, unemployment checks, or SSI, SSD, public assistance benefit notifications **for all members of household**.
- If patient is a minor, financial records of parent/guardian need to be submitted.
- **All income earners in household need to submit these items.**

BILLS (in PDF format)

- Copies of **current** bills that you are requesting to be paid. Must include account number and mailing address of vendor. **Please prioritize which bills are most crucial to receive help with.**
- Checks are not issued payable to the grant recipient. They will be sent to you, but payable to the company you have requested payment to (rent, mortgage, medical bills, utilities, etc.). Thus, we will need copies of those bills that include the account number and mailing address.
- If you are requesting help with rent, submit a copy of your rental lease that includes your name, amount of rent, landlord's name and mailing address where payments are made.

MEDICAL REPORTS (in PDF format)

- Copy of pathology report, if you have had biopsy/surgery.
- Copy of most recent MRI report (**not MRI scan**)

PHOTOS

- Submit **several** high quality pictures in **jpg** format **of you**. High quality photos are imperative. Scanned pictures will not suffice, so **if you are emailing them, please send as attachment to the email**. If sent separate from application, please send them digitally in jpg format to **ggf@glenngarcelonfoundation.org** and put your name in the subject line.
- We are unable to return photos to you, so be sure to only send those you have duplicates of.
- **Do not send copy of driver's license OR photos of your head following surgery**

OPTIONAL ITEMS

while not required, including these items will help the Review Committee get to know you better

- **PERSONAL STORY** (in PDF format)
 - On a separate sheet of paper, please tell us about you, so that we may get to know more about you. **We want to know about you: career, interests, family**, what life was like both before and since your diagnosis, etc.
- **TESTIMONIAL** (in PDF format)
 - Have a family member or close friend tell us about you. We want to get to know you from someone else's perspective. (**please do not have them write about your brain tumor journey**)

PLEASE INITIAL YOUR CHOICE: If I am awarded a grant, _____ I DO or _____ I DO NOT agree to allow my picture and/or story to be used by the Glenn Garcelon Foundation on the Grant Recipient page on the GGF website and for raising awareness.

Signature of applicant or guardian _____ date _____

GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE AND INITIALS

**MEDICAL INFORMATION
TO BE PROVIDED BY APPLICANT/PATIENT**

Date of diagnosis _____ If this is a recurrence, date of original diagnosis _____

Neurosurgeon's or doctor's **name and phone number (REQUIRED)** _____

Social Worker's /Patient Advocate name and phone number and email

Oncologist's **name and phone number (if applicable)** _____

Hospital where receiving treatment(s) _____

DEMOGRAPHICS

(Your responses are private and will only be used for our records. They will **not** be used to determine your eligibility for a grant.)

What is applicant's ethnic origin?

- African American/Black
- Arab American
- Asian
- Hawaiian/Pacific Islander
- Latino/Latina/Latinx
- Multiracial
- Native American/Indigenous
- South Asian
- White/Caucasian
- Other (please specify) _____

What is applicant's age?

- Under 10 years old
- 10-17 years old
- 18-25 years old
- 26-35 years old
- 36-48 years old
- 48-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older

What is applicant's marital status?

- Married
- Domestic Partnership
- Divorced
- Separated
- Single, never married
- Widowed

What is applicant's gender?

- Man
- Woman
- Non-binary (neither, both or something else) Please specify _____

How did you learn about the Glenn Garcelon Foundation?

- friend website news article doctor/social worker web search social media event other _____

I certify that the information on this page is true and accurate.

Signature of applicant or guardian

date

Patient Signature

I give permission for my doctor(s) to provide information and reports about my medical condition and treatment to the Glenn Garcelon Foundation. Further, I give permission to hospital personnel to provide additional information about my needs to the Glenn Garcelon Foundation. I certify that neither I nor anyone other than a medical professional treating me for my brain tumor completed ANY part of this page other than my signature above.

MEDICAL PERSONNEL REPORT

This section can ONLY be completed by your oncologist, neurosurgeon, neurologist (or a nurse in one of those offices), social worker or other health care professional treating you for your brain tumor.

Patient Name Patient DOB

Date of Diagnosis: Type of brain tumor WHO Grade

Circle one: benign malignant unknown at this time Primary brain tumor? Yes No

If secondary, location of primary cancer? Recurrence? Yes No

Is patient in active treatment? Yes No If not in active treatment, how often do you see the patient?

Please indicate type(s) of treatment(s) patient has received (circle all that apply)

Chemotherapy Radiation MRI Surgery Palliative care
Bone marrow/stem cell transplant Other (specify)

Please indicate type(s) of treatment(s) patient might need in the future (circle all that apply)

Chemotherapy Radiation MRI Surgery Palliative care
Bone marrow/stem cell transplant Other (specify)

In your opinion, is the patient able to work at this time (if a minor, is parent unable to work due to caregiving responsibilities)?

HEALTH CARE PROFESSIONAL INFORMATION (please print)

Doctor's name: Hospital/Clinic:

Address, City, State, Zip

Phone: Fax:

Name and Title of person completing this section, if different than above (please print)

Phone Email:

Your relationship to person applying for help: Doctor Nurse Social Worker Other

Signature of Medical Professional

Date

IF POSSIBLE WRITE A SHORT STATEMENT ON THE PATIENT'S MEDICAL CONDITION OR ATTACH CLINIC NOTES OR LETTERHEAD/OR ENVELOPE ASSOCIATED WITH THE CLINIC/HOSPITAL COMPLETING PAGE.

If you wish to speak with us, please call (503-969-7651) or email completed form to ggf@glenngarcelonfoundation.org

All information is strictly confidential and is for Glenn Garcelon Foundation use only

GRANT APPLICATION CHECKLIST

Your application cannot be forwarded to the Review Committee until we have received the packet in its entirety. Be sure all parts have been completed and signed as requested. Do not use staples or tape on any pages.

We will contact you via email if additional information is needed, so be sure to **ADD** gjf@glenngarcelonfoundation.org AND sarah@glenngarcelonfoundation.org to your contact list. Once your application has been reviewed, we will notify you by email if we need additional information.

EITHER mail the complete Grant Application (pages 1-5) and additional required items to Glenn Garcelon Foundation, PO Box 3142, Coppell, TX 75019 (DO NOT USE STAPLES) or email legible scanned pages (in PDF format only) to gjf@glenngarcelonfoundation.org. **Note:** photos must be in jpg format

If you have any questions, contact us at 503-969-7651 or gjf@glenngarcelonfoundation.org

Please be aware that funds are limited and based on availability and need.

Before submitting application, please check to be sure you have completed/included the following:

Page 1

- Personal information fully completed
- Signature

Page 2

- Financial information fully completed
- Signature

Page 3

- Proof of income for each employed person in household
- Current bills requesting payment for
- Medical reports (pathology and recent MRI)
- Photos (high quality, preferably digital) ATTACH to email when sending
- We are unable to return photos, so send those you have duplicates of
- Optional items:
 - Personal story
 - Narrative written by friend or family member
 - Initial choice to allow or disallow use of photo/story
 - Signature

Page 4

- Medical information fully completed
- Demographic Section completed
- Signature

Page 5

- Signature at top of page

You may not complete any portion of this page. It must be completed by the doctor treating you for your brain tumor (neurosurgeon, oncologist, neurologist, or a designated person in their office).