



## Glenn Garcelon Foundation

empowering & supporting brain tumor patients

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.

In addition to the application, there are other required items that need to be submitted. Applications go to the Review Committee the 25<sup>th</sup> of each month so your application must be received in its entirety no later than the 23<sup>rd</sup> to be considered for that month (with the exception of December, when the review will be on the 15<sup>th</sup>, so all items are needed no later than the 13<sup>th</sup>).

**Please add [ggf@glenngarcelonfoundation.org](mailto:ggf@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](mailto: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 US territories. Applicants must reside in and be receiving treatment in the United States to be eligible.*

*What is the amount given to a qualified applicant?*

*Grants are need based and the maximum given to a qualified applicant is \$1000.*

*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 [HYPERLINK mailto:ggf@glenngarcelonfoundation.org](mailto:ggf@glenngarcelonfoundation.org)  
[ggf@glenngarcelonfoundation.org](mailto: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 25<sup>th</sup> of each month, with the exception of December when they are reviewed on the 15<sup>th</sup>. Your packet must be received in its entirety no later than the 23<sup>rd</sup> (13<sup>th</sup> 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 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 6 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**)

**OPTIONAL ITEMS**

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

- **PHOTOS** (in JPG or PNG format) **Do not** send copy of driver's license
  - Submit **several** high quality pictures in **jpg** format. High quality photos are imperative as they will be placed on our website, and perhaps at fundraising events, in promotional materials and/or in meetings with potential donors/sponsors. Scanned pictures will not be high quality enough, so **if emailing, please attach to email**. If sent separate from application, please send them digitally in jpg format to [gjf@glenngarcelonfoundation.org](mailto:gjf@glenngarcelonfoundation.org) and put your name in the subject line. Note: we do not need photos of your head following surgery.
  - We are unable to return photos to you, so be sure to only send those you have duplicates of.
  
- **PERSONAL STORY** (in PDF format)
  - On a separate sheet of paper, please "tell your story" so that we may get to know more about you and the journey you are on. **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 on the Glenn Garcelon Foundation website, at fundraising events, and as needed to further the mission of the Foundation.

Signature of applicant or guardian

date

**GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT SIGNATURE**

**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 (REQUIRED)  
\_\_\_\_\_

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

**GRANT APPLICATION WILL NOT BE REVIEWED WITHOUT 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 \_\_\_\_\_

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 \_\_\_\_\_

**PLEASE WRITE A SHORT STATEMENT ON THE PATIENT'S MEDICAL CONDITION AND YOUR FINANCIAL NEEDS ASSESSMENT OF THIS PATIENT OR ATTACH LETTERHEAD OR ENVELOPE ASSOCIATED WITH THE CLINIC/HOSPITAL COMPLETING THIS PAGE.**

If you wish to speak with us, please call (503-969-7651) or email completed form to [ggf@glenngarcelonfoundation.org](mailto: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](mailto:gjf@glenngarcelonfoundation.org) to your contact list. Once your application has been reviewed, we will notify you by email.

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 HYPERLINK "mailto:gjf@glenngarcelonfoundtion.org" [gjf@glenngarcelonfoundtion.org](mailto:gjf@glenngarcelonfoundtion.org). **Note:** photos must be in jpg format

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)
- Optional items:
  - Personal story
  - Narrative written by friend or family member
  - Photos (high quality, preferably digital) ATTACH to email when sending
    - We are unable to return photos, so send those you have duplicates of
- 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).