MARY E. SMITH (M.O.M.) FOUNDATION, INC./MEMORIES OF MARY
20650 S. Cicero Avenue #827
Matteson, IL. 60443
www.maryesmithfoundation.org

FINANCIAL ASSISTANCE APPLICATION

Eligibility:

All applicants must be U.S. residents. Candidates must be the brain tumor patient; parent/guardian of; or a financially bound relative of a person diagnosed with a brain tumor. Relationships are limited to spouse, children, parents, and siblings. All applications require the signature of the patient/parent/guardian and must be accompanied by proof of a brain tumor diagnosis. Supporting documentation regarding financial hardships during and/or following the diagnosis should also accompany the application (ex. past due hospital bills).

Note: *Funds will be distributed on a first come first serve basis (check website for availability). Funds are made payable to the patient; parent/guardian. Maximum amount awarded is $2500.00.*

- **A.** "**A HUSBANDS HOPE"**
  - Must be the HUSBAND of the brain tumor patient.
  - Must demonstrate financial hardship during and/or after the diagnosis.

- **B. "A WIFE'S WISH"**
  - Must be the WIFE of the brain tumor patient.
  - Must demonstrate financial hardship during and/or after the diagnosis.

- **C. "A CHILD CARES"**
  - Must be age 18 or older.
  - Must be the CHILD of the brain tumor patient.
  - Must be a caretaker of the brain tumor patient.
  - Must demonstrate financial hardship during and/or after the diagnosis.

- **D. "MY BROTHER'S/SISTER'S KEEPER"**
  - Must be age 18 or older.
  - Must be the SIBLING of the brain tumor patient.
  - Must be a caretaker of the brain tumor patient.
  - Must demonstrate financial hardship during and/or after the diagnosis.

- **E. "A PERSISTENT PATIENT"**
  - Must be a brain tumor SURVIVOR or parent/guardian of a minor previously or currently diagnosed with a brain tumor.
  - Must demonstrate financial hardship during and/or after the diagnosis.

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CHOOSE ONE:

☐ ***A Husband's Hope*** ☐ ***A Wife's Wish*** ☐ ***A Child Cares*** ☐ ***My Brother's/Sister's Keeper***

OR CIRCLE ONE: PATIENT or PARENT or GUARDIAN of a minor patient age <18

PRINT Parent/Guardian Name: _____

Patient Name:_____
First Middle Last

Address:_____
Street City State Zip code

Telephone: ( )_____ **OR ( )**_____ **Email:**_____

If different from above:
Applicant; Parent/Guardian

Name:_____
First Middle Last

Address:_____
Street City State Zip code

Telephone: ( )_____ **OR ( )**_____ **Email:**_____

- **Type of Tumor**_____
- **Date of Diagnosis** _____
- **Hospital/Medical Facility Name (the facility that made the diagnosis)**_____

_____
Facility Address City State Zip

Phone:_____

I have read and understand the terms of this financial award and will comply with all the requirements. If selected as a grant recipient, it may be necessary to provide additional information and/or verification to Mary E. Smith (M.O.M.) Foundation, Inc./Memories of Mary. I further agree to grant permission to my healthcare provider/facility to disclose mine or my loved one's diagnosis. If I am the patient, I certify that I willingly provided my medical information solely for the purpose of gaining financial support. I/We certify that the information provided is accurate to the best of my/our knowledge.

Today's Date _____ **Amount Requested** _____

Patient; Parent/Guardian Signature (if patient age <18) _____

Applicant Signature _____