Trevor Loughlin Foundation, Inc.
PATIENT GRANT APPLICATION

Mission Statement:

The Trevor Loughlin Foundation, Inc. is dedicated to assisting individuals battling blood cancers and other acute catastrophic illnesses in the Hudson Valley NY region (or with a nexus to the Trevor Loughlin Foundation, Inc.)

The Trevor Loughlin Foundation, Inc. has a limited amount of discretionary funds that can be used to assist patients and their families with medical and related living expenses incurred while trying to get well, and grants are being made for such purpose.

Eligibility Requirements:

- You are a current patient, undergoing treatment.
- You have been diagnosed with a blood cancer or acute catastrophic illness.
- You are in financial need.
- You reside in the Hudson Valley, NY region, or are an individual residing elsewhere who has a sufficient nexus to the Trevor Loughlin Foundation, Inc. (as determined by the Trevor Loughlin Grant Committee).

General Information

The Trevor Loughlin Foundation will issue grants in an amount up to $1,500. Grant monies can be applied to expenses incurred while getting well, including, but not limited to:

- Car Payment
- Medical Bill/Medications
- Rent/Mortgage
- Travel Expenses Related To Treatment
- Utilities

Grant Application Process for Patient to Follow:

Step 1: Determine eligibility
Step 2: Complete the Application (FORM A)
Step 3: Complete the Physician Medical Release Form (FORM B)
Step 4: Complete the Patient Medical Release Forms (FORM C)
Step 5: Copy of photo-ID; if under 18, Parent/Guardian ID as well
Step 6: Copy of any receipts/invoices/statements/bills evidencing costs for which you are seeking reimbursement. (Not required but helpful to our process.)
Step 6: Return all original forms, and a copy of photo-ID, and any other supporting documentation to:

Trevor Loughlin Foundation, Inc.
492 Old Sackett Rd
Rock Hill, NY 12775

To expedite processing, you may scan and email the completed application to:
sloughlin@trevorloughlinfoundation.org

Please also mail original forms. The application will processed immediately upon receipt.

A representative of the Trevor Loughlin Foundation, Inc. may follow up with you as part of this process. In some circumstances the foundation may choose to pay some of your expenses directly to the billing entity directly.

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FORM A

PATIENT NAME____

PHONE NUMBER_________________________________EMAIL____

DATE OF BIRTH____

MAILING ADDRESS____

____

EMPLOYER NAME/ADDRESS____

EMERGENCY CONTACT NAME/TELEPHONE NUMBER______________________________________

____

DIAGNOSIS AND TREATMENT PLAN____

____

NAME & TELEPHONE NUMBER OF TREATING PHYSICIAN__________________________________

HEALTH INSURANCE PLAN____

GRANT AMOUNT REQUESTED?____

HOW WILL THIS GRANT BE SPENT?____

____

DOCUMENTATION FOR EXPENSE/COST/INVOICE IS ATTACHED: YES ______ NO ______

WHO REFERRED YOU TO US?____

T SHIRT SIZE: CIRCLE ONE XS S M L XL 2X

I HEREBY AGREE THAT THE INFORMATION CONTAINED WITHIN THIS GRANT APPLICATION PACKET CAN BE SHARED WITH THE TREVOR LOUGHLIN FOUNDATION, INC. BOARD OF DIRECTORS AND GRANT COMMITTEE.

I AGREE TO PROVIDE TREVOR LOUGHLIN FOUNDATION WITH RECEIPTS THAT CORRELATE TO THE SPENDING OF GRANT FUNDS.

I ALSO AGREE THAT THE TREVOR LOUGHLIN FOUDNATION, INC. MAY SHARE GENERAL INFORMATION ABOUT THIS GRANT IN ORDER TO INCREASE SUPPORT AND OBTAIN CONTRIBUTIONS, SO THAT OTHERS MAY BE HELPED IN THE FUTURE: DIAGNOSIS, AGE, GENDER, AND GENERAL RESIDENTIAL LOCATION. E.G. THIS YEAR WE HELPED A 23 YEAR OLD WOMAN BATTLING OVARIAN CANCER IN SULLIVAN COUNTY.

PATIENT SIGNATURE____DATE______________

OR PARENT SIGNATURE (if under 18)

MAIL ORIGINAL FORM TO: Trevor Loughlin Foundation / 492 Old Sackett Road / Rock Hill, NY 12775

Contact TLF with any questions: 845 423 5017 or 845 313 0777

Trevor Loughlin Foundation, Inc.
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FORM B

MEDICAL RELEASE OF INFORMATION TO: TREVOR LOUGHLIN FOUNDATION, INC.
To Be Completed By Treating Physician

1. Name of Patient: ______________________________Patient's date of birth: ____/____/___

2. Patient's diagnosis: (you may attach information on a separate sheet with letterhead)

____
____
____

3. Date of diagnosis: ____

4. Current treatment plan:____

5. When did you begin treating this patient? ____

6. Expected duration of treatment:____

Physician Name: ____

Physician Telephone #____

Physician Address____

I see the patient: Daily* Weekly *Monthly *Other (specify) ________________________________

Signature of Physician _______________________________________ Date: ____________________

MAIL ORIGINAL FORM TO: Trevor Loughlin Foundation / 492 Old Sackett Road / Rock Hill, NY 12775
Contact TLF with any questions: 845 423 5017 or 845 313 0777

Trevor Loughlin Foundation, Inc.
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FORM C

PRIVACY STATEMENT AND MEDICAL RECORDS RELEASE

To be completed by Patient

PRIVACY STATEMENT:

The privacy of your personal and medical information is important to the Trevor Loughlin Foundation, Inc. and we are committed to protecting your information. Your records will be conscientiously maintained by Trevor Loughlin Foundation, Inc. following federal United States Health & Human Services HIPAA regulations. In order to uphold the level of service that you expect from our organization, we may need to share limited personal information in the following ways:

- For coordination of payment of services funded;
- To verify information from your doctor and/or health practitioner;
- To obtain funding for Trevor Loughlin Foundation, Inc. (statistics that do not include your name will be used in this situation);
- With board members of Trevor Loughlin Foundation, Inc. to make decisions for your funding.

I authorize my treating physician, identified in Form A, to release the information requested in Form B to Trevor Loughlin Foundation, Inc. I also authorize the physician to speak to a representative from Trevor Loughlin Foundation, Inc. to verify information if needed for a grant I am requesting.

Signature of Patient:____________________________________ Date: _____________________
or Signature of Parent of Legal Guardian if patient is under the age of 18.

PLEASE PRINT:

Name of Patient: ____

Address of Patient: ____ __

Phone: ___________________________________Email:________________________________ ___

THIS AUTHORIZATION EXPIRES IN 90 DAYS AFTER IT IS SIGNED

MAIL ORIGINAL FORM TO: Trevor Loughlin Foundation / 492 Old Sackett Road / Rock Hill, NY 12775
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