Trevor Loughlin Foundation, Inc.
PATIENT GRANT APPLICATION

Mission Statement:

The Trevor Loughlin Foundation, Inc. is dedicated to assisting individuals diagnosed with blood cancers and other acute catastrophic illnesses in the Hudson Valley NY region.

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 (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: Have your Physician Complete the Physician Medical Release Form **(FORM B)**

Step 4: Complete the Patient Medical Release Forms **(FORM C)**

Step 5: Provide copy of photo-ID; if under 18, Parent/Guardian ID as well

Step 6: Provide copy of any receipts/invoices/statements/bills evidencing costs for which you are seeking reimbursement.

Step 6: Return all forms, and a copy of photo-ID, and any other supporting documentation via mail or email to:

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

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

The application will be processed upon receipt.

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

TREVOR LOUGHLIN
foundation

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FORM A

PATIENT NAME_____

PHONE
NUMBER_____EMAIL_____

DATE OF BIRTH_____

MAILING ADDRESS_____

_____

EMPLOYER NAME/ADDRESS_____

EMERGENCY CONTACT NAME/TELEPHONE NUMBER_____

_____

ARE YOU CURRENTLY EMPLOYED? ___YES ___ NO. If NO, LAST DATE OF EMPLOYMENT: _____

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?_____

REFERRAL CONTACT INFO: TELEPHONE_____ EMAIL_____

I HEREBY AGREE THAT THE INFORMATION CONTAINED WITHIN THIS GRANT APPLICATION PACKET CAN BE SHARED WITH THE TREVOR LOUGHLIN FOUNDATION, INC. ("TLF") BOARD OF DIRECTORS AND GRANT COMMITTEE, AS WELL AS OTHER NON-PROFIT ORGANIZATIONS TLF SUBMITS THIS APPLICATION TO FOR ADDITIONAL FUNDING.

I AGREE TO PROVIDE TLF WITH RECEIPTS THAT CORRELATE TO THE SPENDING OF GRANT FUNDS.

I ALSO AGREE THAT TLF 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)

Trevor Loughlin Foundation / 492 Old Sackett Road / Rock Hill, NY 12775
Contact TLF with any questions: 845 313 0777

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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: _____

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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 and/or Grant Committee members of Trevor Loughlin Foundation, Inc. to make decisions for your funding.
- With other non-profit organizations that may be able to provide you with additional grant funds (e.g., Celebrate Life Half Marathon, Allyson Whitney Foundation).

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 or their representative 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: _____ __

Patient Phone: _____Patient Email:_____ ___

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER IT IS SIGNED